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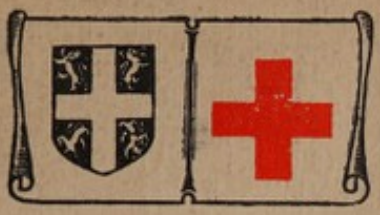

The VOLUNTARY HOSPITALS *in* GREAT BRITAIN

(EXCLUDING LONDON)

Sixth Annual Report for the Year 1924

By

F. N. KAY MENZIES
M.D., F.R.C.P.Ed., D.P.H.,
Director of Hospital Services, Joint Council of the Order of St. John and the British Red Cross Society

PRICE: ONE SHILLING

With a Foreword by the

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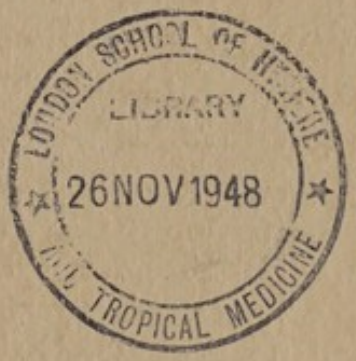

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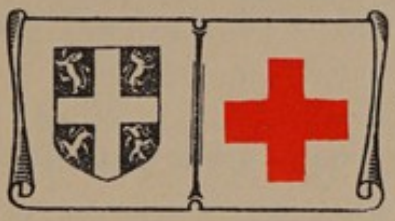

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AND THE

BRITISH RED CROSS SOCIETY.

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Foreword.

By the Hon. Sir ARTHUR STANLEY, G.B.E., C.B., M.V.O.

Chairman of the Joint Council of the Order of St. John and the British Red Cross Society.

The Sixth Annual Report of the Joint Council of the Order of St. John of Jerusalem and the British Red Cross Society concerning the Provincial Hospitals of Great Britain is specially interesting for two reasons :—

(1) The articles on particular branches or phases of Hospital work.

(2) That portion of Dr. Menzies's survey which is devoted to the Report recently issued by the Voluntary Hospitals Commission.

I feel sure that those who read the Report, to which this is a foreword, will welcome the articles contributed by Mr. H. N. Crouch, Sir A. Lisle Webb, Mr. H. Souttar, Mr. N. Bishop Harman, Dr. J. G. Johnstone and Sir D'Arcy Power, each of whom has special knowledge of the subject upon which he writes. It is hoped to make the inclusion of articles, such as these, an annual practice.

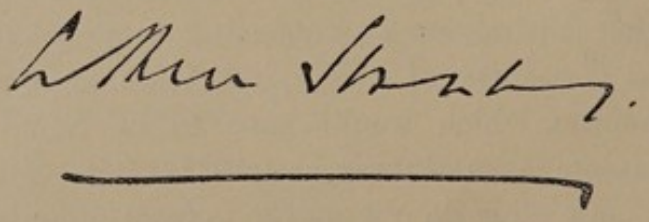
The Report of the Voluntary Hospitals Commission is very clearly summarised and its findings are carefully considered and weighed. One striking conclusion at which Dr. Menzies arrives is that the Voluntary Hospitals themselves could find the extra 10,000 beds asked for by the Voluntary Hospitals Commission, *if they doubled the normal rate of increase of their bed accommodation during the next five years.* The normal rate is estimated to be 1,000 beds per year, which sounds a large figure until one remembers that there are in Great Britain 911 Voluntary Hospitals with over 50,000 available beds. Of course, the required increase in accommodation is not uniformly spread over the whole country, but the figure I have quoted shows that it is not such an alarming proposition as it appears at first sight. Personally, as Treasurer of a Hospital, I am more anxious about the extra £1,250,000 per annum which would have to be found by the Voluntary Hospitals for the maintenance of these new 10,000 beds, but Dr. Menzies and the Voluntary Hospitals Commission do not appear to have any misgivings on this point, which may possibly be due to the fact that they are not Treasurers of a Hospital, as I am.

I agree with the general conclusions arrived at by Dr. Menzies. If 10,000 beds are required at once we must have financial help from the State, and this is certainly the case where a comparatively large number of beds has to be provided in a newly populated district such as Becontree. Here the beds cannot be obtained by the extension of an already existing institution, but have to be provided by the building of a new Hospital. That is too great a demand to make upon the newly formed community.

Dr. Menzies refers to the suggestion which I have put forward on several occasions, that a Central Fund for the benefit of Provincial Hospitals should be established on somewhat similar lines to those of King Edward's Fund for London Hospitals. I will not enter into arguments in favour of the establishment of this Fund which seems to me to be long overdue. I need only point to the success of King Edward's Fund, not only from the financial point of view, but also from the influence which such a Fund can have in bringing about the much needed co-ordination of Hospital work. Anything that can make individual Hospitals realise that they are part of one single organisation for the health and welfare of the whole community and not isolated entities must be a step in the right direction.

To one smaller point I should like to draw attention. Dr. Menzies estimates that if bequests to Hospitals were exempted from Legacy Duty the gain to the Voluntary Hospitals of England and Wales, including London, would be £150,000 per annum —a small sum in the annual budget of the nation but one which in a few years would make a vast difference in the budgets of the Hospitals. If State assistance could be thus vicariously given I believe that we should hear no more suggestions of Hospitals " going on " the rates or the Exchequer.

There are many other items to which I should like to allude, but I must bear in mind that this is only a foreword to a very interesting Report. On behalf of the Joint Council I thank the Hospitals for the way in which they have helped in the compilation of this survey by sending in their reports and answering the questions that have been put to them. The fact that no less than 95·21 per cent. of the total Hospitals in the Provinces including 98·50 per cent. of the total available beds have come under review in this Report shows that it meets a real demand and that the authorities governing these 755 Hospitals are keenly interested not only in their own work, but also in that of their colleagues, in the arduous but fascinating task of bringing health and strength to the whole community.



September, 1925.

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INTRODUCTION.

I.—THE OBJECT OF THE REPORT.

The object which the Joint Council have in mind in issuing this Report (or Survey) is the presentation in as full detail as possible of the position of the Provincial Voluntary Hospitals in Great Britain with reference to certain special features which may be summarised thus :—

(*a*) The facilities available for treatment.

(*b*) The extent to which they are utilised by the community generally.

(*c*) The annual cost of maintaining these facilities, and

(*d*) The sources and extent of the funds by which they are maintained.

Throughout this Report the Hospitals reviewed are grouped under the headings :—

Group A. Hospitals having **100** or more beds.
Group B. Hospitals having **30** to **99** beds.
Group C. Hospitals having less than **30** beds.

Tables are also given of Hospitals having Medical Schools attached, and of the General and Special Hospitals in each Group.

In our last year's Report we said :—

" Those who attempt any such Survey as the Joint Council have in mind are, of course, compelled to rely, mainly at all events, upon the Reports which are issued to their Subscribers annually by the Voluntary Hospitals. Even a superficial glance at these Reports is sufficient to enable any person to realise that, quite naturally, they vary to a considerable extent in the amount of information which they contain and the manner in which this information is presented. It is, perhaps, not altogether surprising that some of the Reports omit certain data which are absolutely essential for the purposes of a satisfactory Survey, while others prepare their accounts in a manner which, to say the least, renders the task of analysis and tabulation extremely difficult."

We also gave two Tables in illustration of the difficulties encountered in summarising Hospital Finance and Statistics. We publish below two similar Tables which show that there still remain considerable obstacles in the way of a really satisfactory survey. We confidently believe that these will in the course of time disappear.

METHOD OF PUBLISHING ACCOUNTS.

Hospitals.	Number of Hospitals using Revised Uniform System, including a Balance Sheet.	Number of Hospitals using Revised Uniform System, but not publishing a Balance Sheet.	Number of Hospitals using other methods, but publishing a Balance Sheet.	Number of Hospitals using other methods, and not publishing a Balance Sheet.
Group A	76=67%	26=23%	3= 2%	9= 8%
Group B	60=31%	44=22%	28=14%	65=33%
Group C	49=14%	41=12%	35=10%	226=64%
Total	185=28%	111=17%	66=10%	300=45%

METHOD OF PUBLISHING BED ACCOMMODATION AND AVERAGE OCCUPATION.

Hospitals.	Hospitals giving both the available beds and the average number occupied.	Hospitals giving number of available beds, but not the average occupation.	Hospitals giving the average number of beds occupied, but not the total number available.	Hospitals giving neither available beds nor average occupation.
Group A	72=63%	2= 2%	37—32%	3= 3%
Group B	71=36%	14= 7%	67=34%	45=23%
Group C	52=15%	49=14%	123=35%	127=36%
Total	195=30%	65=10%	227=34%	175=26%

The above Tables taken as a whole show no improvement upon the year 1923, and we have, therefore, no hesitation in repeating the paragraph at the top of page 9 in our Report for 1923, viz. :—

> " The moral of these remarks would therefore appear to be that for such a Survey, as is here attempted, to be thoroughly reliable, some measure of uniformity should be observed by Hospitals, great and small, in the preparation of their Annual Reports. It is not suggested that they should entirely confine their Reports to a model schedule, but rather that for the common good, certain essential data should be included in all Annual Reports, and that these should be prepared and presented in common form."

II.—THE SCOPE OF THE REPORT.

This Report reviews 95.21 per cent. of the total Hospitals, containing 98.50 per cent. of the total available beds, leaving unreviewed 38 Hospitals containing 677 beds.*

	Total number of Hospitals reviewed in this Report.	Available beds.	Total possible number of Hospitals.	Available beds.
England and Wales	662	36,831	693	37,309
Scotland	93	7,583	100	7,782
Total ...	755	44,414	793	45,091

* In the London area there are 118 hospitals, with 13,460 available beds. There are, therefore, in Great Britain 911 Voluntary Hospitals, with 58,551 available beds.

The number of Hospitals reviewed in the present and four previous Reports is shown in the following Tables :—

ENGLAND AND WALES.

Number of Hospitals.			Available beds.		
1920	572	88·41% of the total	32,892		96·94 % of the total
1921	581	90·64% of the total	33,356		95·54 % of the total
1922	587	90·45% of the total	33,968		96·16 % of the total
1923	624	93·70% of the total	36,078		97·66 % of the total
1924	**662**	**95·53%** of the total	**36,831**		**98·72** % of the total

SCOTLAND.

Number of Hospitals.			Available beds.		
1920	78	82·98% of the total	6,606		94·63 % of the total
1921	75	83·34% of the total	6,887		94·46 % of the total
1922	79	86·52% of the total	7,075		96·53 % of the total
1923	86	96·63% of the total	7,326		98·72 % of the total
1924	**93**	**93·00%** of the total	**7,583**		**97·44** % of the total

The additional Hospitals reviewed in 1924, being all of the small type, and many of them publishing this year their first Annual Reports, account for only a very small proportion of the total.

We have eliminated from this Report certain Hospitals (six in number), which receive the greater portion of their income from Government and Municipal Authorities. Tables 22 and 23 are thereby affected by comparison with former years, and a note to this effect is appended to these Tables.

It may be as well, also, to point out that the Report contains no data with reference either to Hospitals for Incurable Diseases or to Convalescent Homes which are not under the management of a parent Hospital.

III.—GENERAL SUMMARY OF THE FINANCES OF THE HOSPITALS REVIEWED IN 1924.

England and Wales.

Ordinary Income	£4,540,667	Ordinary Expenditure	£4,526,182
Extraordinary Income and Receipts for Capital Purposes	1,655,182	Extraordinary and Capital Expenditure	1,216,524
	£6,195,849		£5,742,706

Scotland.

Ordinary Income	£814,892	Ordinary Expenditure	£869,374
Extraordinary Income and Receipts for Capital Purposes	899,031	Extraordinary and Capital Expenditure	148,407
	1,713,923		1,017,781
Total Receipts	£7,909,772	Total Expenditure	£6,760,487

It is more than probable that there has never been any year in which all the Voluntary Hospitals paid their way. The Voluntary Hospital budget is largely built on faith, and the justification, which History has always endorsed, does not necessarily take place within the financial year. Therefore, it is that, although the surplus of one Hospital is not available to meet the deficit of another, we may yet be allowed to regard that year as a financially successful one in which for all the Voluntary Hospitals the total credits exceed the total debits.

Taking all the Hospitals in England and Wales, it will be seen that there was a balance to the good for the year 1924 of £453,143 and in Scotland of £696,142.

ORDINARY INCOME AND ORDINARY EXPENDITURE.

We give, as in former years, the figures which show the relationship between what is known in the Hospital World as Ordinary Income and Ordinary Expenditure.

In 1920 Ordinary Income *failed* to meet Ordinary Expenditure by £541,114.
In 1921 Ordinary Income *failed* to meet Ordinary Expenditure by £419,138.
In 1922 Ordinary Income *failed* to meet Ordinary Expenditure by £74,978.
In 1923 Ordinary Income *exceeded* Ordinary Expenditure by £213,694.
In **1924** Ordinary Income *failed* to meet Ordinary Expenditure by **£39,997.**

Percentage of Hospitals with a Surplus of Ordinary Income :—

	Great Britain.	*England and Wales.*	*Scotland.*
1920 ...	44 per cent.	45 per cent.	42 per cent.
1921 ...	51 per cent.	53 per cent.	39 per cent.
1922 ...	57 per cent.	57 per cent.	53 per cent.
1923 ...	66 per cent.	67 per cent.	62 per cent.
1924 ...	**61** per cent.	**62** per cent.	**54** per cent.

We include in the Report for the first time a Table of the Legacies received during 1924. It is not possible to say how a similar Table, had such been prepared for 1923 or any of the preceding years, would have influenced the figures. It is more than probable that in no year since 1920 would there have been any failure to meet the cost of maintenance out of moneys raised and available for the purpose. In any case the Table shows as clearly as possible that the relationship of Ordinary Income to Ordinary Expenditure is no indication of the solvency of the Hospitals individually or as a whole. The figures for Scotland are interesting—Free Legacies were more than sufficient to pay half the Ordinary Expenditure.

LEGACIES RECEIVED DURING THE YEAR.

ENGLAND AND WALES.

Hospitals.	No. of available beds in Hospitals reviewed.	Free Legacies.	Earmarked Legacies.	Total Legacies.	Per available bed.*		
					Free.	Earmarked.	Total.
Group A ...	21,624	£ 279,773	£ 92,159	£ 371,932	£ 13	£ 4	£ 17
Group B ...	9,958	128,921	22,200	151,121	13	2	15
Group C ...	5,249	45,384	7,900	53,284	9	2	11
Total ...	36,831	£ 454,078	£ 122,259	£ 576,337	£ 12	£ 3	£ 15

SCOTLAND.

Hospitals.	No. of available beds in Hospitals reviewed.	Free Legacies.	Earmarked Legacies.	Total Legacies.	Per available bed.*		
					Free.	Earmarked.	Total.
Group A ...	5,495	£ 385,828	£ 87,883	£ 473,711	£ 70	£ 16	£ 86
Group B ...	1,244	94,438	9,838	104,276	76	9	85
Group C ...	844	15,303	5,800	21,103	18	7	25
Total ...	7,583	£ 495,569	£ 103,521	£ 599,090	£ 65	£ 14	£ 79

* Calculated to the nearest £.

INVESTED FUNDS AND THE INTEREST DERIVED THEREFROM.

In this connection the growth in the amount of Invested Funds and the Interest arising therefrom is of particular interest.

Hospitals in	Year.	Invested Funds.		Interest from Investments.	
		Total.	Per available bed.	Total.	Per available bed.
England and Wales ...	1920	£ 11,515,857	£ 350	£ 561,544	£ 17·09
	1924	**15,029,758**	**408**	**711,253**	**19·31**
Scotland	1920	2,900,122	422	136,687	20·69
	1924	**4,565,650**	**602**	**205,850**	**27·14**

IV.—PATIENTS TREATED DURING 1924.

Out of the 755 Hospitals the finances of which are reviewed in this Report, six Hospitals with 199 beds do not give details with regard to the number of patients treated during 1924. Consequently the following summary of work is not quite co-extensive with the summary of finance. The difference is, however, so small as to be practically negligible.

NUMBER OF PATIENTS TREATED.

	No. of Hospitals giving details.	No. of available beds.	Total No. of New In-Patients.	Total No. of New Out-Patients.	Total No. of New Patients.
		England and Wales.			
Medical School Hospitals ...	14	4,857	85,037	545,019	630,056
Non-Medical School Hospitals	643	31,809	417,762	1,591,751	2,009,513
		Scotland.			
Medical School Hospitals ...	6	3,218	52,916	182,389	235,305
Non-Medical School Hospitals	86	4,331	58,354	177,326	235,680
Total	749	44,215	614,069	2,496,485	3,110,554

The figures go to show a steady increase in the number of In-patients and Out-patients treated in both England and Wales and Scotland. The increase in Out-patients is particularly noticeable.

V.—THE REPORT OF THE VOLUNTARY HOSPITALS COMMISSION.

The Voluntary Hospitals Commission were requested by Mr. Wheatley " to enquire into and to report upon the extent of the additional Voluntary Hospital accommodation required in England and Wales, and the best means of providing and maintaining it."

The Report of the Commission, published in August of this year, has been justly described as " a document of real public interest, for its subject concerns everybody." It is also true to say that the recommendations contained in the Report have been generally approved.

The principal sources upon which the Commission relied for the information upon which their recommendations were based, were as follows :—

(*a*) Special reports by the Local Voluntary Hospitals Committees throughout England and Wales, including, in the case of London, the King Edward's Hospital Fund Committee.

(*b*) In certain sample areas (urban, semi-urban and rural) these reports were checked by Medical Officers of the Ministry of Health, and, in addition, special reports were made by these officers in certain areas.

(*c*) A further independent check was made, at the request of the Commission, by the British Medical Association through certain of their local branches.

The total additional beds required for England and Wales was finally put by the Commission at 10,000, and the " bare cost of the additional beds to be provided " at £400 per bed, involving, therefore, a minimum capital expenditure of £4,000,000.

All those who have any comprehensive knowledge of the position in regard to Voluntary Hospital accommodation in this country will agree that, if anything, these two figures are an under-estimate rather than an over-estimate of actual requirements.

The Commission recommend that any grants made by the Government shall be limited to 50 per cent. of the " bare cost of the additional beds to be provided," *i.e.*, £200 per bed and a maximum total grant of £2,000,000. In practice, this will mean that certain important items of capital outlay, such as cost of site, furniture, equipment, &c., will not be eligible for grant.

We estimate that the total capital expenditure involved in the provision of 10,000 additional beds will be not less than £5,000,000 (*i.e.*, £500 per bed), and that the maintenance of these beds, when provided, will cost the Voluntary Hospital Committees concerned at least £1,250,000 per annum (*i.e.*, £125 per bed per annum).

The Voluntary Hospitals which received the capital grants would, therefore, have to raise in the aggregate an additional £3,000,000 for capital expenditure. On the other hand, if the Voluntary Hospitals decided that they would not accept any Government grant, or, as is much more likely, the Government decided not to make any capital grant at all, then the whole of the £5,000,000 capital expenditure would fall upon the supporters of the Voluntary Hospitals.

It would probably take about five years to build, equip and staff the 10,000 new beds, and, if the Government accepted the recommendations of the Commission, arrangements would probably be made to pay over the proposed grant by instalments at the rate of, say, £400,000 per annum.

Assuming that all the data above given are correct, or, at all events, approximately correct, it seems to be worth while asking ourselves this question : " Can the Voluntary Hospitals themselves, within the next five years, *provide and maintain, without State aid,* the additional 10,000 beds said to be required ? "

We have taken some considerable amount of trouble to ascertain from the numerous Hospital reports and other records in our possession, some reliable information which might be useful to our readers in helping them to arrive at an intelligent answer to this question.

THE CAPITAL EXPENDITURE INVOLVED IN NEW CONSTRUCTION.

The Voluntary Hospitals Commission, after a careful consideration of all the information before them, confessed that they were reluctantly driven to the conclusion that " a substantial measure of State assistance is essential to enable the Voluntary Hospitals to overtake the arrears which have accumulated in the last ten years."

From the information in our possession, it would appear that the rate of increase in bed accommodation during the four years from 31st December, 1920, to 31st December, 1924, of Hospitals in England and Wales (excluding London) is approximately as follows :—

1920	...	...	...	...	33,930
1921	...	...	...	...	34,913
1922	...	...	...	...	35,324
1923	...	...	...	...	36,982
1924	...	...	...	...	38,611

These figures show a total increase of 4,681 beds in the Voluntary Hospitals of England and Wales (excluding London), during the four year period, or an average increase of over 1,100 beds per annum.

In the case of London, the corresponding figures appear to be as follows :—

1920	...	...	...	...	12,851
1921	...	...	...	...	12,751
1922	...	...	...	...	12,976
1923	...	...	...	...	13,253
1924	...	...	...	...	13,865

The figure for 1924 includes certain extension schemes which are in hand. The total increase is approximately 1,000 beds, or an average annual increase of about 250 beds.

In the period under review (1920-1924) it is of considerable interest and importance to note that the Voluntary Hospitals of England and Wales, including London, have, out of their own financial resources, succeeded in increasing their accommodation by well over 5,000 beds.

We think, however, that it would be wise to regard this rate of increase of bed accommodation as above the normal increase which might reasonably be anticipated in the immediate future. The period under consideration coincided with the distribution of large sums of money connected, directly or indirectly, with charitable funds raised during the Great War, such as, *e.g.*, the Demobilisation Grants of the Joint War Committee of the British Red Cross Society and the Order of St. John of Jerusalem, which alone exceeded one million pounds.

Therefore, it would be more prudent to estimate the normal increase of accommodation at, say, 1,000 beds per annum, and, if we assume that during the next five years this rate of increase of bed accommodation obtains, then it will be seen that about one-half of the additional beds which the Commission consider necessary will be forthcoming in the ordinary course of events and from the ordinary financial resources upon which the Voluntary Hospitals rely for their support to-day.

The problem with which we are faced, therefore, may be expressed in the following terms :—

(*a*) Can the Voluntary Hospitals of England and Wales, including London, double the normal rate of increase of their bed accommodation during the next five years?

(*b*) Can this be done by the Voluntary Hospitals themselves without the State aid recommended by the Voluntary Hospitals Commission?

In order to double the normal increase of beds from 1,000 to 2,000 per annum during the next five years, it will be necessary for the supporters of the Voluntary Hospitals to raise a Special Building Fund of £2,500,000.

The amount involved is undoubtedly large, but spread over a period of five years, it does not come to more than an additional sum of £500,000 per annum, and then looks a rather less formidable undertaking. (We deal with the question of maintenance later.)

On the other hand, it is fair to add, that if the Government agreed to the recommendation of the Voluntary Hospitals Commission and made a Capital grant for building purposes of £2,000,000, it is obvious that the problem of providing the additional beds required would be reduced to much simpler proportions.

ALTERNATIVE SUGGESTIONS TO THE RECOMMENDATIONS OF THE VOLUNTARY HOSPITALS COMMISSION.

Since the publication of the Report of the Voluntary Hospitals Commission several letters have appeared in the public press in which suggestions have been put forward with a view to avoiding the necessity for a large Government grant, as recommended by the Commission. They may be summarised as follows :—

(1) Closer co-operation between Hospitals, large and small; general and special.

(2) Relief, complete or partial, from local rate charges.

(3) Exemption from legacy duty of bequests to Hospitals.

(4) The provision of additional bed accommodation by means of recovery and convalescent homes.

The first suggestion is an ideal, with which everyone desirous of securing efficient Hospital administration, will be in entire agreement, but, unfortunately, it has proved in practice to be an ideal, almost unattainable, and so we are afraid it will ever remain until something changes the " independence " of the Britisher.

The last suggestion (No. 4) is fully dealt with in a paper by Mr. Orde and myself, which appears on page 87 of this Report, and to which, therefore, we may refer any of our readers who are particularly interested in this question.

Freedom, Total or Partial, from Local Rate Charges.—It is extremely difficult to calculate to what extent the Voluntary Hospitals of England and Wales (including London) would benefit if they were entirely exempted from local rates. We have analysed the accounts of a very large number, and have satisfied ourselves that " complete freedom " might possibly represent a sum of about £100,000 per annum, if all the Voluntary Hospitals in England and Wales (including London) were completely exempted from local rate charges.

On the other hand, those who advocate " complete freedom from local rates " overlook two important facts, viz.: (1) That, in very many towns, Voluntary Hospitals are already " beneficially rated," and (2) that Hospitals, like other ratepayers, benefit considerably from certain municipal services, *e.g.*, scavenging, refuse and sewage disposal, street lighting, &c.

We are not in a position to express any opinion upon this suggestion from the legal point of view, but it is possible that, even if they were so disposed, Local Authorities might not have power to remit rate charges entirely. In any event, we think that it is extremely unlikely, for the reasons above given, that such a proposal would be generally adopted.

Exemption from Legacy Duty of Bequests to Hospitals.—The amount likely to be yielded by exemption from Legacy Duty can only be accurately calculated by His Majesty's Treasury, but we have made an effort to arrive at a fair estimate, and on the information before us we think that if such bequests were exempted from Legacy Duty, the Voluntary Hospitals of England and Wales (including London) would probably benefit to the extent of £150,000 per annum.

It should, however, be borne in mind that this sum would represent a permanent loss of revenue to the Treasury. We are unable to believe that if the Lords of the Treasury had to choose between (*a*) the permanent loss of revenue of £150,000 per annum, and, possibly, in the course of time a much larger sum; and (*b*) a lump sum contribution of a definite amount over a fixed term of years, as suggested by the Voluntary Hospitals Commission, there would be any hesitation on their part in deciding in favour of the latter rather than the former.

Moreover, it is only fair to point out that for some years to come, the Hospitals which would stand to gain the most from such a proposal would be the old-established institutions, and not those which either have been recently built or may have to be built in the rapidly growing urban areas where more Hospital accommodation is urgently needed.

Central Hospital Fund for Provincial Hospitals.—There is still another alternative which, although very strongly advocated by the Hon. Sir Arthur Stanley, has not, as yet, succeeded in securing favourable consideration or support, but which appears deserving of some further consideration by Voluntary Hospital Committees and their Secretaries throughout England and Wales.

The proposal, put very briefly, is that a Central Fund for the benefit of Provincial Hospitals should be established on somewhat similar lines to those of King Edward's Fund for London Hospitals. This suggestion was first brought forward in the year 1922 at the Annual Meeting of the British Hospitals Association at Liverpool, and referred to the Council of that Association for the purpose of drafting a scheme. The Draft Scheme was submitted at the next Annual Meeting held at Sheffield in 1923 and rejected, upon what would seem, to those who have read the discussion thereon, as somewhat inadequate grounds. Since that date various attempts have been made from time to time to revive the proposal, but so far without success. It may well be, however, that the time is now more opportune for giving it yet another trial run.

Those who favour this scheme believe, and they have good grounds for their belief, that such a Central Hospital Fund for the Provincial Hospitals would prove in the course of a few years to be at least as successful as King Edward's Fund for the London Hospitals. It may, therefore, be permissible to point out, especially to those who dislike the idea of a large Government subvention, under any conditions, that such a Central Fund appears to afford one more possible expedient worthy of trial. It might even be worth while for the Government to consider whether, if such a Fund were established under suitable auspices, they would, before finally committing themselves to the recommendation of the Voluntary Hospitals Commission, give it a good launch, as it were, by means of a donation of, say, £100,000. The most obvious objection, of course, to any such scheme, in so far as the provision of 10,000 new beds is concerned, is that time is of the essence of the problem, and many years would probably have passed away before such a Fund could grow to any considerable dimensions.

We fully realise that, apart from the suggestions upon which we have commented, there may be many other methods by which the additional capital sums necessary for the specific purpose of providing the additional bed accommodation may be raised. But we hope we have succeeded in conveying to the minds of our readers, in board outline, the nature and extent of the problem from the point of view of the capital expenditure involved.

MAINTENANCE OF ADDITIONAL BEDS.

We turn now to the question of maintenance, and in this connection we should like at once to emphasise the fact that the problem of maintenance differs materially from that of capital expenditure in one most important respect, viz., that while the Voluntary Hospitals Commission have reluctantly been forced to the conclusion that "a substantial measure of State assistance" is necessary for the provision of the 10,000 additional beds, they do

not anticipate any serious difficulty upon the part of the Voluntary Hospital Committees concerned in raising the extra annual cost of maintenance which will arise as and when the additional beds are made available.

Let us now endeavour to analyse the position from the point of view of maintenance.

SOME OF THE SOURCES OF ORDINARY INCOME OF THE VOLUNTARY HOSPITALS IN ENGLAND AND WALES (EXCLUDING LONDON).

	Source.	Amount received in		Increase.	Decrease.
		1920.	1924.		
		£	£	£	£
Table 19	Interest from Investments, &c.	561,544	711,253	149,709	—
20	Workmen's Contributions and Contributory Schemes ...	830,533	1,249,153	418,620	—
21	Patients' Contributions ...	348,253	644,214	259,961	—
22 and 23	Income from Public Services	570,325	378,680†	—	191,645
25	Subscriptions	567,576	638,203	70,627	—
25	Donations, Entertainments, Collections, &c.	547,355	719,253	171,898	—
26	Congregational Collections ...	*158,466	166,501	8,035	—
		£3,620,052	£4,507,257	£1,078,850	£191,645
				191,645	
			Nett increase	£887,205	
	From the Statistical Report of King Edward's Hospital Fund for London the nett increase over approximately the same period would appear to be at least			150,000	
				£1,037,205	

* 1922 figure.

† See comments on page 39.

The above Table is really a consolidation of Tables 19, 20, 21, 22, 23, 25 and 26 of our Report. It sets out the various sources of income, and is both interesting and instructive. It shows that in the year 1924, the nett income of the Voluntary Hospitals in England and Wales (excluding London) has increased, as compared with the year 1920, by no less a sum than £887,205, and if to this sum we add the nett increase in the London Hospitals, which appears to have been at least £150,000 over the same period, we arrive at a total nett increase of well over £1,000,000 in the four year period.

Reviewing the financial position then, *quâ maintenance*, we think that the Commission were probably justified in their view that the Voluntary Hospitals will be able to provide the income of £1,250,000, per annum, which will be necessary in order to maintain the 10,000 additional beds, when available.

We may, therefore, summarise the whole position thus:—

(1) The Voluntary Hospitals Commission, after a careful survey of the position, have reported to the Minister of Health that, in their opinion, at least 10,000 additional beds are required in the Voluntary Hospitals of England and Wales to overtake the arrears which have accumulated in the last ten years.

(2) The Commission estimate the bare cost of providing these beds at £4,000,000, and they recommend that 50 per cent. of this sum should be provided by the Government upon certain conditions.

(3) We have expressed the view that the Total Capital Expenditure involved in the provision of 10,000 new beds, including all charges, will amount to not less than £5,000,000, and the cost of maintenance will be not less than £1,250,000 per annum.

(4) We have submitted an analysis of our statistical records, which show:—

(*a*) That the normal rate of increase of bed accommodation in the Voluntary Hospitals of England and Wales, including London, may be estimated at not less than 1,000 beds per annum.

(*b*) That the normal rate of increase must be doubled during the next five years in order to meet the existing shortage of beds in these Hospitals.

(*c*) That in order to double the normal annual increase of beds it will become necessary for the supporters of the Voluntary Hospital system to raise, during the next five years, a " special Building Fund " of £2,500,000.

(*d*) That certain alternatives to the Government Grant, recommended by the Voluntary Hospitals Commission, such as, the complete remission of local rate charges and exemption of Hospital bequests from Legacy Duty are unlikely to be adopted by the authorities concerned, but that a Central Fund for the benefit of the Provincial Hospitals, similar in character to that of King Edward's Fund for London Hospitals, is a suggestion well worthy of consideration.

(*e*) That there are substantial grounds for the belief that the additional income, amounting to £1,250,000 per annum, required for the maintenance of the 10,000 additional beds will be found by the supporters of the Voluntary Hospitals as and when required.

The conclusion at which we have ourselves arrived is that on the whole the Voluntary Hospitals Commission, by means of an entirely independent series of enquiries, have gauged to a nicety the position in the Voluntary Hospitals of England and Wales, and that bearing in mind the high costs of building; the prolonged prevalence of acute trade depression, which unfortunately shows no definite signs of coming to an end for a long time yet; and the great burden which the Voluntary Hospitals are in any event asked to undertake *quâ* the maintenance of the 10,000 additional beds, they were fully justified in recommending that the Government should make a substantial grant towards the large Capital Expenditure involved in the provision of the additional beds.

Finally, we think that, all those who have the welfare of the Voluntary Hospitals at heart should not overlook the importance of the fact that the evidence before the Commission went to show that the need for additional hospital accommodation in certain areas is very acute, and that, therefore, time is of the essence of the problem. The issues at stake are too grave to justify procedure at a leisurely pace.

VI.—PENSIONS FOR NURSES.

We are sure that all our readers will feel greatly indebted to Mr. Crouch for his exceedingly able and thoughtful paper on the very difficult problem of " Pensions for Nurses." The paper is thoroughly practical and puts forward constructive proposals with which we are glad to find ourselves in cordial agreement, even though they may require some modification in consequence of the recent passage into law of Mr. Neville Chamberlain's Widows', Orphans' and Old Age Contributory Pensions Act.

VII.--CO-OPERATIVE PURCHASE FOR HOSPITALS.

Whatever may be thought of the progress of co-operation between Hospitals in certain other directions, there can be no doubt that co-operative purchase, which at first sight would seem to afford considerable scope for economy, has made either little or none. Indeed the lack of success which has attended all efforts in this direction would seem to justify, without further argument, the comparative indifference with which it is regarded. And yet, superficially, at all events, the arguments in its favour appear irrefutable, and certainly the experience of the business community points strongly in the direction of the immense economies to be gained by central purchase.

In these days when every expedient for the reduction of unnecessary expenditure should be thoroughly explored, it seemed to us well worth while endeavouring to place upon record, before it was too late, the experience of a Government Department which temporarily was responsible for the maintenance of an exceptionally large unit of Hospital beds—patients, medical, nursing and domestic staff. We are very grateful, therefore, to Colonel Sir Lisle Webb, Director-General of Medical Services, Ministry of Pensions, for the valuable article on this subject which sets forth clearly and concisely the almost unique experience of the Department over which he so ably presides.

The keynote to the success of Central Purchase for the Ministry of Pensions Hospitals is probably to be found in the fact that " standardisation " on a large scale was possible. But, although this is true of a number of articles used in Ministry of Pensions Hospitals, it is surely equally true of most of our Voluntary Hospitals. The real trouble in the practical application of any comprehensive scheme of co-operative purchase to our Voluntary Hospitals is that in the matter of purchase, as in so many other things, all our Voluntary Hospitals are a law unto themselves, and, unfortunately, this view is encouraged and approved not only by the Hospital Committees themselves, but by the Medical Staff and the Matron and Nursing Staff. The very idea of " standardisation " is anathema to them. They detest it in any shape or form. They pride themselves on the very fact that it is the last thing in the world which they would even contemplate introducing into the Voluntary Hospital system. Moreover, they will take pains to point out to you that it is just the very thing, above all things, which distinguishes and differentiates them from Government and Municipal Institutions. And yet, if this question of co-operative purchase is intelligently thought out, are there not any articles of standard size, strength, &c., which are in common use, or, at least, might equally well be adopted, in practically all our Voluntary Hospitals? What about the following articles merely as a few examples :—

Carbolic acid.
Ether.
Rice.
Sugar.
Tea.
Lints.
Wools.
Soaps.
Various drugs.
Bed sheets.
Blankets.

It may very well be that certain of our large General Hospitals could not under any system of co-operative purchase secure any better terms for themselves. We do not pretend to express any opinion upon this point, but we find it difficult to believe, in the light of the experience set forth in Sir Lisle Webb's article, that there are no big economies to be secured by the adoption in certain areas of a scheme of co-operative purchase for a limited number of the articles in common use throughout the Voluntary Hospitals of this country.

VIII.—HOSPITAL ACCOMMODATION FOR THE MIDDLE CLASSES.

This subject is dealt with in a paper (page 112) by Mr. Souttar, and also formed the subject of a paper by Sir William Milligan at the Annual Meeting of the British Hospitals Association at Manchester in June last.

The main argument in both papers is the same, viz., that the considerable strides made by medical science in the last 25 to 30 years necessitates, for the adequate diagnosis and treatment of disease, the provision of highly technical equipment, such as can only be satisfactorily used and successfully applied by specially skilled persons and in specially designed institutions. For these reasons their use is to all intents and purposes limited either to the very rich who can afford to pay for them, or the very poor who get all such advantages by utilising our Voluntary Hospitals. Everyone is agreed that that large section of the community, called, for convenience, the "Middle Classes," but more accurately the "New Poor," is more frequently than not deprived of many of the advantages arising from these modern developments of medical science, and hence the demand is becoming, and rightly so, more insistent year by year, for some solution of this problem.

Paying Wards in our Voluntary Hospitals are favoured by Mr. Souttar; whereas Sir William Milligan leans decidedly in favour of "Pay Hospitals," as separate specially designed annexes, as it were, to our existing Voluntary Hospitals.

There do not appear to us to be any particular reasons why the necessary provision should not be made in various suitable centres throughout England and Wales of "Paying Wards" in the one case, and "Pay Hospitals" in the other case in accordance with local needs, local prejudices and local facilities. We know of equally successful examples of both types and even of a mixture of both in connection with one institution.

The most important point at the moment is that the need for such accommodation is evidently becoming more and more fully realised by Hospital Committees, and that the movement is slowly but steadily going forward. Moreover, we are emphatically of opinion that those Hospitals which attempt to meet the need are not only doing a very real service to a section of the community which most deservedly merits such consideration, but, that, ultimately the much more general provision of such a type of Hospital accommodation will prove to be very sound policy on the part of Voluntary Hospitals Committees themselves.

IX.—HOSPITALS, GENERAL AND SPECIAL.

Mr. Bishop Harman's paper upon the much vexed question of General and Special Hospitals is distinguished by the lucidity and impartiality with which he sets forth the advantages and disadvantages of General Hospitals with special departments, as against Special Hospitals set up *ad hoc* to diagnose and treat certain special diseases. The conclusion at which he arrives is quite definitely in favour of the General Hospital with a range of (special) departments, covering all modern requirements, and he claims that this is not only the trend of opinion in this country, but also in America. We are entirely in agreement with his conclusion, and would add that it is a significant fact of modern times that this trend of opinion applies just as emphatically to all business and industrial organisations.

X.—ELECTRIC COOKING IN HOSPITALS.

Dr. Johnstone has been good enough to write an interesting and practical paper on a very difficult subject. Probably our readers will, like ourselves, feel that the experience of Heatherwood Hospital, though very valuable, is not sufficiently convincing at the moment to justify us in

expressing any definite opinion as to the comparative costs of steam, coal and electricity for cooking purposes in Hospitals and other similar large institutions. There are so many different conditions to be taken into account that one only conclusion seems to be fairly certain, and it is that a great deal depends upon local circumstances. Thus the price of coal per ton, of gas per therm, and of electric current per unit, varies within very wide limits in different areas throughout England and Wales.

The problem may present a totally different aspect some years hence when some of the big power schemes, now in existence or being developed, enable electric current to be supplied at a much cheaper rate per unit. In the meantime, therefore, while commending Dr. Johnstone's valuable contribution to the notice of our readers, we throw out the suggestion that the question is one well worthy of much more detailed investigation by such central bodies as the British Hospitals Association and the Council of King Edward's Hospital Fund. In fact, we think that the latter body, being in possession of large funds, might well consider the desirability of subsidising one or more Hospitals of different types in order to carry out some practical experimental work in this direction. There can be little doubt that such information would prove to be of great practical value to Hospital Committees throughout the country.

XI.—PAWNBROKINC AND HOSPITALS.

Many of our readers will no doubt be somewhat surprised, but, we hope, at least interested, in the article by Sir D'Arcy Power on this subject. The paper originates from the discovery by my colleague, Mr. Orde, in an old bookshop, of a small pamphlet, dated 1836, entitled " An Address to the Inhabitants of Limerick on the Opening of the Mont de Piété." Knowing the intense interest and profound knowledge of Sir D'Arcy Power in all matters concerning the History of Medicine, we sent him the pamphlet and expressed the hope that if he found the subject sufficiently interesting, he would be so good as to write a short article thereon for this issue of our Hospital Report. We also had the curiosity to enquire as to whether there was at the moment any living descendant of the late Mr. Matthew Barrington who could give us any information as to the subsequent history of this almost unique institution in so far as Great Britain and Ireland are concerned. We were fortunate enough to get into touch with Sir Charles Barrington, Bart., a near relative of the founder of the Mont de Piété at Limerick. Sir Charles very kindly came to see us at 19, Berkeley Street, and subsequently, at our request, wrote a letter, extracts from which we publish as an addendum to Sir D'Arcy Power's article. We are deeply indebted to both of these gentlemen for so kindly assisting us to place on record the origin and subsequent history of a type of Hospital, of which, so far as we are aware, there has been no other example in this country. We cannot refrain from adding that from the financial point of view alone—more's the pity.

I desire to express my sincere thanks to all those Hospital Superintendents and Secretaries throughout Great Britain who have been good enough, not only to send us their Annual Reports so soon as they are published, but also to supply us, where necessary, with a good deal of supplementary information of considerable importance.

It is quite impossible for me to give adequate expression to the profound sense of gratitude which I feel towards my colleagues, Mr. R. H. P. Orde and Mr. A. E. Ceadel, for their invaluable assistance in the production of this Report.

F. N. Kyrmegis.

September, 1925.

SECTION 1.

VOLUME OF WORK DONE IN THE VOLUNTARY HOSPITALS IN ENGLAND AND WALES.

In England and Wales in 657 Hospitals with 36,666 beds available—98.28 per cent. of the available total—502,799 new In-patients and 2,136,770 new Out-patients were treated in 1924. If we make allowance for the remaining 1.72 per cent. of the beds we shall not be far from the truth in saying that during the year 1924 the English and Welsh Provincial Voluntary Hospitals provided 37,000 beds and treated 510,000 In-patients and 2,200,000 Out-patients.

These 37,000 beds are divided, approximately, between the three groups A, B and C, in the ratio of 4, 2 and 1, while the In-patient work is divided in the ratio 5, 2 and 1 and the Out-patient of 10, 3 and 1.

The pressure on the A Group of Hospitals deserves special consideration. It has now reached a point at which 88.33 per cent. of the beds are kept in constant occupation. This pressure is further accentuated by the rate at which patients are passed through the beds. In the 14 Medical School Hospitals, where the average occupation reaches almost 90 per cent., approximately 20 patients are treated in each bed annually. Periods of high occupation (and in a Hospital, owing to the various sub-divisions of the work, 85 per cent. may be considered high) are to be expected from time to time, but constant pressure such as these figures reveal are a clear indication that there is a real need for an increase in bed accommodation, either by adding beds to the existing Hospitals or by providing beds elsewhere, *e.g.*, by means of Auxiliary Hospitals, etc.

Nor should consideration be given only to the In-patient work. In each group, especially the A Group, Out-patient work has steadily increased since 1920. It would have been interesting to show the tendency in each of the various Out-patient departments. Unfortunately, the figures are not given in the reports in sufficient detail for this purpose, and we are obliged to confine ourselves to an approximate gross total. We have, however, examined those reports in which a continuous record under the various departmental headings does happen to be given, and, if one may judge of the whole from a few examples, the rise, though slightly more marked in the Ophthalmic and Aural departments, has been, with the exception of Venereal work, a general one. Out-patient work seems to have reached a peak in 1911; then, owing to the National Health Insurance Act and afterwards to the Great War, the numbers fell until 1920. From 1920 onwards they have risen each year until now they exceed the figure for the year 1911.

This rise in Out-patient work is a matter of considerable importance. Out-patient departments are costly and account for from one-quarter to one-fifth of the total ordinary annual expenditure of a hospital. Its effect on the finances of the Medical School Group, for example, in which one-quarter of the whole of the Out-patient work of all the English and Welsh Provincial Voluntary Hospitals is done, is, therefore, very considerable.

Table 2 is of importance because of its bearing on Tables 11 and 16 referred to later. It shows that the ratio of Out-patient to In-patient work decreases in the General Hospitals and increases in the Special Hospitals as the institutions become smaller. The actual figures are :—

	No. of New Out-Patients to each New In-Patient.	
	General Hospitals.	*Special Hospitals.*
Group A	4.80 ...	5.41
Group B	2.59 ...	5.49
Group C	1.75 ...	6.41

Out-patients work bulks largely in the Special Hospitals, and particularly in those devoted to Ophthalmic and Aural work. This fact, as well as the actual composition of each group of Special Hospitals, must be taken into consideration before any estimate is formed as to the relative costs of General and Special and of large Special and small Special Hospitals. The Special Hospitals in each group are composed of the following:—

Hospitals.	*A Group.*	*B Group.*	*C Group.*
Babies	—	2	—
Cancer	—	3	1
Chest	—	—	1
Children	3	17	1
Eye, Ear, Nose and Throat	2	15	16
Maternity	—	7	5
Mineral Water	3	3	—
Nervous Diseases	—	2	—
Orthopædic	—	1	1
Skin	—	1	1
Venereal	—	1	—
Women	4	5	7
	12	57	33

TABLE 1.

NUMBER OF IN-PATIENTS AND OUT-PATIENTS TREATED AND PERCENTAGE OF AVAILABLE BEDS OCCUPIED.

Hospitals.	Year.	No. of Hospitals giving details.	No. of available beds.	Percentage of available beds occupied daily.	No. of New In-patients.	No. of New Out-patients.
Group A ...	1920	106	20,056	81·92%	248,426	1,191,016
	1921	108	20,525	80·67%	257,638	1,269,118
	1922	108	20,730	82·17%	260,066	1,273,792
	1923	115	22,071	82·75%	295,303	1,426,178
	1924	**114**	**21,624**	**88·33%**	**317,871**	**1,545,380**
Group B ...	1920	160	8,202	76·78%	97,619	388,707
	1921	160	8,234	74·57%	93,710	353,315
	1922	159	8,180	73·01%	95,575	342,957
	1923	183	9,116	72·68%	112,758	424,108
	1924	**195**	**9,836**	**74·15%**	**124,515**	**438,644**
Group C ...	1920	289	4,122	69·43%	50,363	130,851
	1921	301	4,359	61·79%	50,643	144,720
	1922	304	4,446	59·23%	47,395	110,589
	1923	322	4,766	62·79%	53,773	118,908
	1924	**348**	**5,206**	**60·96%**	**60,413**	**152,746**
Total ...	1920	555=97% (*a*)	32,380=98% (*b*)	—	396,408	1,710,574
	1921	569=98% (*a*)	33,118=99% (*b*)	—	401,991	1,767,153
	1922	571=97% (*a*)	33,356=98% (*b*)	—	403,036	1,727,338
	1923	620=99% (*a*)	35,953=99% (*b*)	—	461,834	1,969,194
	1924	**657=99%** (*a*)	**36,666=99%** (*b*)	—	**502,799**	**2,136,770**

(*a*) Percentage of Hospitals reviewed.

(*b*) Percentage of beds in Hospitals reviewed.

TABLE 2.

NUMBER OF PATIENTS TREATED IN GENERAL AND SPECIAL HOSPITALS DURING 1924 SHOWN SEPARATELY.

Hospitals.	No. of Hospitals giving details.	No. of available beds.	No. of New In-patients.	No. of New Out-patients.
General Hospitals—				
Group A	102	19,561	286,860	1,377,363
Group B	138	6,855	84,441	218,513
Group C	315	4,616	50,295	87,873
Total of General Hospitals ..	**555**	**31,032**	**421,596**	**1,683,749**
Special Hospitals—				
Group A	12	2,063	31,011	168,017
Group B	57	2,981	40,074	220,131
Group C	33	590	10,118	64,873
Total of Special Hospitals ...	**102**	**5,634**	**81,203**	**453,021**

TABLE 3.

NUMBER OF SURGICAL OPERATIONS (under general anæsthetic).

Hospitals.	Year.	No. of Hospitals giving details.	No. of available beds, and percentage of total reviewed.	No. of operations.
Group A	1921	97	18,481=90%	192,052
	1922	101	19,503=93%	215,935
	1923	105	19,872=90%	238,594
	1924	**109**	**20,739=96%**	**268,834**
Group B	1921	135	7,129=85%	72,088
	1922	135	7,118=84%	76,974
	1923	163	8,327=90%	93,703
	1924	**178**	**9,005=90%**	**104,963**
Group C	1921	201	3,067=68%	32,675
	1922	194	3,006=66%	28,939
	1923	259	3,934=82%	35,608
	1924	**318**	**4,851=92%**	**46,213**
Total	1921	433=74·53%*	28,677=85·97%	296,815
	1922	430=73·25%*	29,627=87·22%	321,848
	1923	527=84·46%*	32,133=89·07%	367,905
	1924	**605=91·39%***	**34,595=93·93%**	**420,010**

* Percentage of Hospitals reviewed.

TABLE 4.

X-RAY DEPARTMENT.

Hospitals.	Year.	No. of Hospitals giving details and percentage of total reviewed	*Total No. of patients treated in those Hospitals.	No. of Radiographs.	No. of Screen Exams.	No. of Treatments.
Group A ..	1922	54=49·54%	786,861	100,630	26,495	50,745
	1923	59=51·30%	1,004,206	143,539	45,889	67,068
	1924	**51=44·74%**	**859,860**	**146,078**	**31,573**	**54,664**
Group B ...	1922	29=17·68%	63,679	9,889	4,867	11,488
	1923	43=23·37%	132,379	15,229	4,963	8,449
	1924	**44=22·34%**	**137,184**	**20,268**	**4,232**	**4,704**

* These patient figures (including both in- and out-patients) do not refer to the work in the department.

TABLE 5.

ELECTRICAL-THERAPEUTIC DEPARTMENT.

Hospitals.	Year.	No. of Hospitals giving details, and percentage of total reviewed	*Total patients treated at those Hospitals.	No. of Treatments given.
Group A	1922	33=30·27%	465,986	311,365
	1923	31=26·96%	396,710	216,889
	1924	**28=24·56%**	**451,781**	**264,200**
Group B	1922	14= 8·54%	36,870	55,175
	1923	17= 9·24%	59,624	56,908
	1924	**10= 5·08%**	**34,568**	**16,027**

* These patient figures (including both in- and out-patients) do not refer to the work in the department.

TABLE 6.

MASSAGE DEPARTMENT.

Hospitals.	Year.	No. of Hospitals giving details, and percentage of total reviewed	*Total patients treated at those Hospitals.	No. of Treatments given.
Group A	1922	46=42·20%	697,728	546,606
	1923	39=33·91%	650,657	479,496
	1924	**38=33·33%**	**729,136**	**490,222**
Group B	1922	17=10·37%	44,627	100,419
	1923	23=12·50%	73,200	68,453
	1924	**21=10·66%**	**67,160**	**52,014**

* These patient figures (including both in- and out-patients) do not refer to the work in the department.

TABLE 7.

SURVEY OF THE WORK DONE IN THE 14 HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN ENGLAND AND WALES.

1	2	3	4	5	6	7	8	9	10
Hospital.	Year.	No. of available beds.	Average No. of beds occupied daily.	Percentage of available beds occupied.	No. of new In-patients.	No. of In-patients per occupied bed.	Average length of stay per In-patient (days).	No. of new Out-patients.	No. of Surgical Operations.
A	1920	324	267·62	82·60	4,198	15·7	23·25	27,110	2,094
	1921	324	260·00	80·25	4,153	16·0	22·85	26,733	3,830
	1922	324	273·59	84·44	4,477	16·4	22·36	26,821	4,233
	1923	324	280·56	86·59	4,780	17·0	21·41	29,116	4,056
	1924	**324**	**277·12**	**85·53**	**5,069**	**18·3**	**19·98**	**31,191**	**4,004**
B	1920	218	174·33	79·96	2,148	12.3	29·58	16,854	—
	1921	218	172·18	78·98	2,355	13·6	26·60	15,822	1,565
	1922	218	181·85	83·41	2,428	13·4	27·49	16,638	1,758
	1923	220	189·50	86·14	2,488	13·1	27·98	18,966	2,173
	1924	**220**	**199·88**	**90 85**	**2,675**	**13·4**	**27·29**	**21,922**	**2,301**
C	1920	400	335·00	83·75	6,930	20·6	17·60	42,376	5,923
	1921	370	317·00	85·68	5,818	18·3	19·70	40,907	4,941
	1922	370	297·00	80·27	5,773	19·4	19·00	42,041	5,421
	1923	370	314·00	84·86	6,153	19·6	18·62	47,696	6,317
	1924	**369**	**318·00**	**86·18**	**6,868**	**21·6**	**16·90**	**51,777**	**7,085**
D	1920	224	182·10	81·29	3,215	17·6	21·80	20,868	3,147
	1921	224	178·80	79·82	3,229	18·0	20·10	19,128	—
	1922	224	180·80	80·71	3,602	19·9	18·30	20,224	3,652
	1923	224	181·70	81·12	3,437	18·9	19·20	23,547	3,751
	1924	**224**	**185.80**	**82·95**	**3,675**	**19·8**	**20·10**	**26,053**	**4,302**
E	1920	363	310·00	85·40	5,302	17·1	14·50	35,482	3,576
	1921	381	335·00	87·93	5,303	15·8	—	34,804	4,089
	1922	381	341·00	89·50	5,487	16·1	—	34,367	4,068
	1923	363	351·00	96·69	5,445	15·5	25·00	38,859	2,609
	1924	**363**	**341·00**	**93·94**	**5,498**	**16·1**	**22·00**	**41,967**	**1,972**
F	1920	236	221·00	93·64	3,499	15·8	23·14	38,379	3,880
	1921	236	204·00	86·44	3,164	15·5	22·23	31,703	3,658
	1922	236	210·00	88·98	3,115	14·8	23·25	32,721	3,323
	1923	316	234·00	74·05	3,683	15·7	23·52	47,926	3,836
	1924	**316**	**274·00**	**86·71**	**4,286**	**15·6**	**23·07**	**39,181**	**4,431**
G	1920	350	245·00	70·00	4,551	18·5	19·60	60,027	—
	1921	297	269·00	90·57	5,368	19·9	18·50	51,888	—
	1922	350	275·60	78·74	5,403	19·6	19·70	44,899	2,436
	1923	350	287·70	82·20	5,766	21·0	17·30	49,102	2,604
	1924	**343**	**300·00**	**87·46**	**6,120**	**20·4**	**17·10**	**56,690**	**6,572**
H	1920	268	230·25	85·91	3,784	16·4	22·14	27,049	—
	1921	268	232·29	86·68	3,843	16·5	22·00	24,688	2,421
	1922	268	239·15	89·24	3,966	16·6	22·01	22,157	2,108
	1923	268	241·88	90·25	4,212	17·4	20·94	25,088	3,422
	1924	**268**	**245·25**	**91·51**	**4,649**	**19·0**	**19·37**	**27,597**	**2,694**
I	1920	622	543·90	87·44	11,550	21·2	18·30	44,071	8,898
	1921	671	529·00	78·84	11,252	21·3	17·16	47,164	8,259
	1922	614	524·46	85·42	11,044	21·1	17·33	46,623	8,049
	1923	614	541·00	88·11	10,696	19·8	17·62	46,596	8,698
	1924	**618**	**539·00**	**87·22**	**10,814**	**20·1**	**17·95**	**42,348**	**8,953**
J	1920	532	390·00	73·31	9,044	23·2	14·50	44,128	9,307
	1921	532	429·00	80·64	9,242	21·5	16·00	42,771	8,231
	1922	546	445·00	81·50	9,785	22·0	15·90	41,857	9,470
	1923	542	461·00	85·06	10,778	23·4	15·05	47,536	10,552
	1924	**542**	**467·00**	**86·16**	**11,248**	**24·1**	**14·60**	**50,777**	**11,403**

TABLE 7.—*continued.*

1	2	3	4	5	6	7	8	9	10
Hospital.	Year.	No, of available beds.	Average No. of beds occupied daily.	Percentage of available beds occupied.	No. of new In-patients.	No. of In-patients per occupied bed.	Average length of stay per In-patient (days).	No. of new Out-patients.	No. of Surgical Operations.
K	1920	550	508·00	92·36	10,332	20·3	17·90	84,125	9,856
	1921	534	512·60	95·99	10,962	21·4	17·00	92,724	11,079
	1922	534	525·40	98·39	11,411	21·7	16·80	93,406	11,755
	1923	534	537·40	100·64	12,159	22·6	16·10	105,426	12,256
	1924	**534**	**539·00**	**100·94**	**12,865**	**23·9**	**15·30**	**110,525**	**12,436**
L	1920	190	176·00	92·63	2,074	11·8	31·00	7,664	1,805
	1921	232	174·00	75·00	2,418	13·9	25·82	8,782	2,454
	1922	210	176·00	83·81	2,984	17·0	22·00	7,733	2,594
	1923	205	169·00	82·44	3,092	18·3	20·40	9,971	2,178
	1924	**205**	**172·00**	**83·90**	**3,339**	**19·4**	**17·45**	**9,521**	**2,446**
M	1920	190	142·00	74·74	2,339	16·4	22·16	9,502	2,590
	1921	190	163·00	85·79	2,326	14·3	25·81	8,982	2,482
	1922	190	168·00	88·42	2,231	13·3	27·46	8,987	2,376
	1923	190	179·00	94·21	2,374	13·3	27·77	10,166	2,596
	1924	**190**	**174·00**	**91·58**	**2,748**	**15·8**	**23·06**	**10,701**	**2,866**
*N	1923	341	318·60	93·43	5,016	15·7	24·33	23,476	4,619
	1924	**341**	**323·80**	**94·93**	**5,183**	**16·0**	**22·80**	**24,769**	**4,738**
Totals ...	1920	4,467	3,725·20	83·26	68,966	18·5	—	457,635	—
	1921	4,477	3,775·87	84·34	69,433	18·4	—	446,096	—
	1922	4,465	3,837·85	85·95	71,706	18·7	—	438,474	—
	1923	4,861	4,286·34	88·18	80,079	18·7	—	523,501	—
	1924	**4,857**	**4,355·85**	**89·68**	**85,037**	**19·5**	—	**545,019**	—

* Recognised as a Medical School during 1923.

SECTION 2.

FINANCIAL POSITION OF THE VOLUNTARY HOSPITALS IN ENGLAND AND WALES.

(A) TOTAL RECEIPTS AND TOTAL EXPENDITURE.
(B) ORDINARY INCOME AND ORDINARY EXPENDITURE.

In the Introduction we have reviewed the financial position of the Hospitals as a whole. We now give the Tables for England and Wales upon which that review is based.

TABLE 8.—During the five-year period Total Receipts have exceeded Total Expenditure by £3,268,294, and in no year, nor in any group, has there been a deficit.

There is no reason to be alarmed at the drop in surplus from £931,063 to £453,143 in 1924. A much larger drop took place in 1921 after the bumper year of 1920.

TABLES 9, 10, 13, 14, 15.—These Tables should be read in conjunction with each other, and with the Legacy Table given in the Introduction. The important point to note is that 62 per cent. of the Hospitals are meeting their maintenance costs without using their free legacies. Were the term "General Fund Income,"* as used in the Tables of King Edward's Hospital Fund for London, adopted throughout the Hospitals of England and Wales, it would be possible to give a truer picture of the financial position from a maintenance point of view.

This Legacy Table (see page 10), which we publish for the first time this year, suggests that at least three-quarters of the Hospitals of England and Wales are able to meet their maintenance expenditure out of their General Fund Income.

Regarding the Hospitals *as a whole* and using the term "Ordinary" in the sense that it does *not* include all moneys available for maintenance purposes, Table 15 shows that Ordinary Income and Ordinary Expenditure exactly met each other.

TABLE 16 shows that the A Group Special Hospitals raise and spend per bed considerably less than the General in the same group. It would be dangerous to draw any conclusion with regard to the B and C Groups, owing to the disturbing factor of the Out-patient department.

TABLES 17 AND 18.—The financial position of the 14 great Medical School Hospitals, which provide rather less than one-seventh of the available beds, and which treat nearly one-sixth of the In-patients and approximately one-quarter of the Out-patients, merits special consideration.

During the past five years an income deficit per occupied bed—and "occupied" and "available" in the group are almost synonymous—has been reduced from £62.58 to £25.86. It is true that 1924 shows a falling off from the high-water mark of 1923, but if we eliminate this peak year, improvement since 1920 has been constant. Since 1920 the Total Receipts of these 14 Hospitals have amounted to £4,788,834 and the Total Expenditure to £4,431,361. In other words they have during five difficult years carried on their work, extended their buildings and their activities, shouldered each new responsibility as it arose and raised more than enough money for the purpose. It is difficult to say whether they could have achieved this result without the financial grants received from :—

(*a*) The Demobilisation Fund of the Joint War Committee of the British Red Cross Society and the Order of St. John.
(*b*) The National Relief Fund.
(*c*) The Voluntary Hospitals Commission.

* General Fund Income is all moneys which under the Revised Uniform System of Hospital Accounts are credited to the Income and Expenditure Account.

It is possible, such is the wonderful financial vitality of the voluntary system, that they could have done so. At the same time it is well to realise that so far as work is concerned times as strenuous lie in front of the Hospitals as those through which they have passed.

TABLE 8.

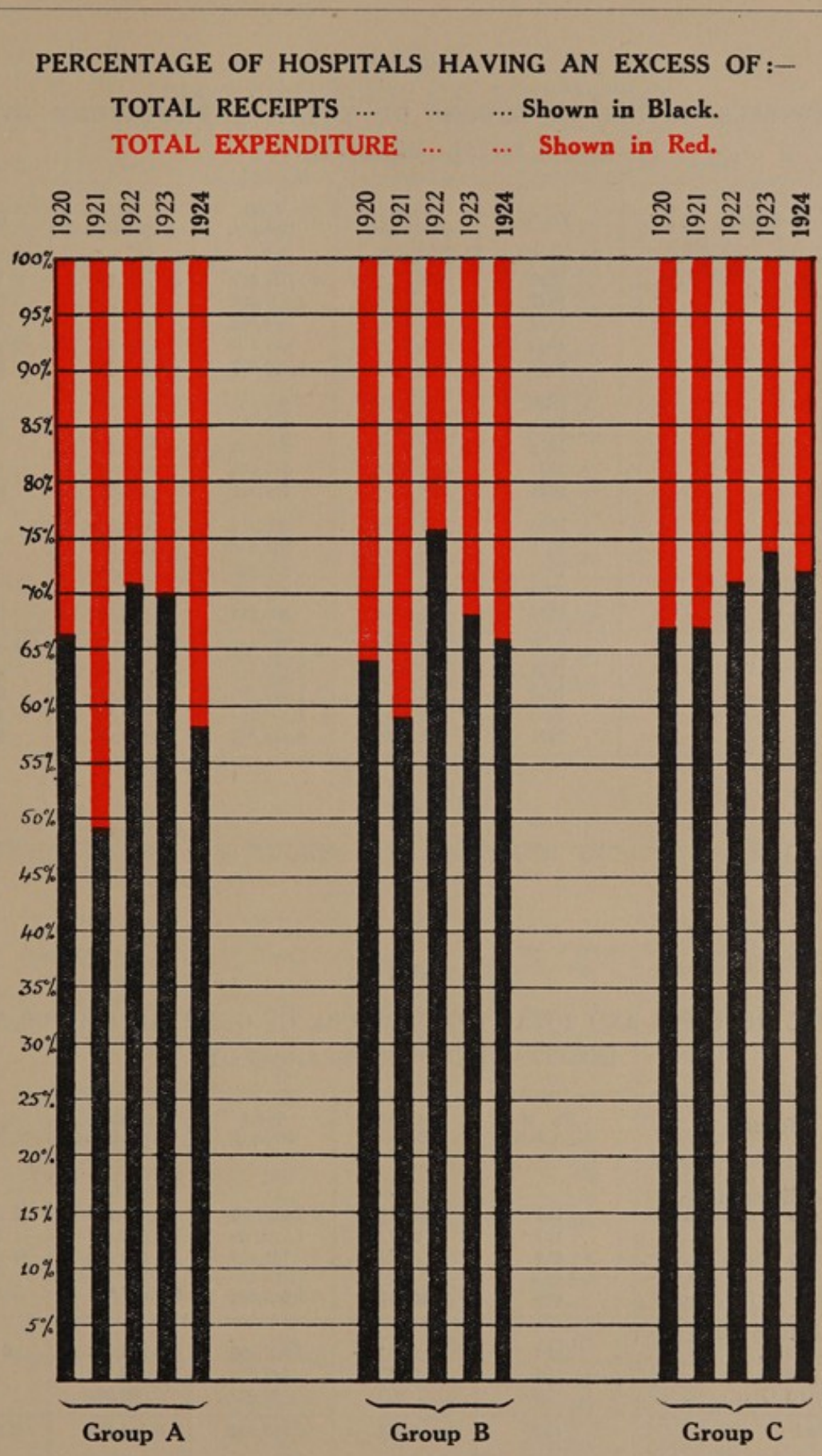
TOTAL RECEIPTS AND TOTAL EXPENDITURE.

Hospitals.	Year.	No. of Hospitals.	Total Receipts.	Total Expenditure.	Surplus.
Group A	1920	107	£ 4,060,073	£ 3,408,452	£ 651,621
	1921	108	3,455,612	3,454,432	1,180
	1922	109	3,491,545	3,127,931	363,614
	1923	115	4,211,350	3,575,704	635,646
	1924	**114**	**3,713,091**	**3,556,831**	**156,260**
Group B	1920	164	1,336,558	1,125,998	210,560
	1921	164	1,309,627	1,185,713	123,914
	1922	164	1,250,681	1,061,348	189,333
	1923	184	1,437,548	1,246,068	191,480
	1924	**197**	**1,658,400**	**1,475,183**	**183,217**
Group C	1920	301	730,245	554,985	175,260
	1921	309	675,858	614,241	61,617
	1922	314	753,712	646,723	106,989
	1923	325	735,887	631,950	103,937
	1924	**351**	**824,358**	**710,692**	**113,666**
Total	1920	572	£ 6,126,876	£ 5,089,435	£ 1,037,441
	1921	581	5,441,097	5,254,386	186,711
	1922	587	5,495,938	4,836,002	659,936
	1923	624	6,384,785	5,453,722	931,063
	1924	**662**	**6,195,849**	**5,742,706**	**453,143**

TABLE 9.

HOSPITALS HAVING AN **EXCESS OF TOTAL RECEIPTS** OVER TOTAL EXPENDITURE.

Hospitals.	Year.	No. of Hospitals.	Total Receipts.	Total Expenditure.	Surplus.
Group A	1920	71 (66%)	£ 3,035,856	£ 2,223,212	£ 807,644
	1921	53 (49%)	1,817,081	1,482,852	334,229
	1922	77 (71%)	2,609,243	2,101,929	507,314
	1923	81 (70%)	3,347,221	2,494,243	852,978
	1924	**66 (58%)**	**2,192,212**	**1,713,102**	**479,110**
Group B	1920	105 (64%)	989,091	721,487	267,604
	1921	96 (59%)	875,717	627,541	248,176
	1922	124 (76%)	1,024,741	786,663	238,078
	1923	126 (68%)	1,062,048	762,146	299,902
	1924	**130 (66%)**	**1,212,639**	**919,582**	**293,057**
Group C	1920	203 (67%)	544,728	335,796	208,932
	1921	206 (67%)	477,788	349,245	128,543
	1922	222 (71%)	601,104	440,734	160,370
	1923	239 (74%)	570,762	414,779	155,983
	1924	**253 (72%)**	**615,483**	**444,146**	**171,337**
Total	1920	379 (66%)	£ 4,569,675	£ 3,285,495	£ 1,284,180
	1921	355 (61%)	3,170,586	2,459,638	710,948
	1922	423 (72%)	4,235,088	3,329,326	905,762
	1923	446 (71%)	4,980,031	3,671,168	1,308,863
	1924	**449 (68%)**	**4,020,334**	**3,076,830**	**943,504**



Illustrating Tables 9 and 10.

TABLE 10.

HOSPITALS HAVING AN **EXCESS OF TOTAL EXPENDITURE** OVER TOTAL RECEIPTS.

Hospitals.	Year.	No. of Hospitals.	Total Receipts.	Total Expenditure.	Deficit.
Group A	1920	36 (34%)	£ 1,024,217	£ 1,180,240	£ 156,023
	1921	55 (51%)	1,638,531	1,971,580	333,049
	1922	32 (29%)	882,302	1,026,002	143,700
	1923	34 (30%)	864,129	1,081,461	217,332
	1924	**48 (42%)**	**1,520,879**	**1,843,729**	**322,850**
Group B	1920	59 (36%)	347,467	404,511	57,044
	1921	68 (41%)	433,910	558,172	124,262
	1922	40 (24%)	225,940	274,685	48,745
	1923	58 (32%)	375,500	483,922	108,422
	1924	**67 (34%)**	**445,761**	**555,601**	**109,840**
Group C	1920	98 (33%)	185,517	219,189	33,672
	1921	103 (33%)	198,070	264,996	66,926
	1922	92 (29%)	152,608	205,989	53,381
	1923	86 (26%)	165,125	217,171	52,046
	1924	**98 (28%)**	**203,875**	**266,546**	**57,671**
Total	1920	193 (34%)	£ 1,557,201	£ 1,803,940	£ 246,739
	1921	226 (39%)	2,270,511	2,794,748	524,237
	1922	164 (28%)	1,260,850	1,506,676	245,826
	1923	178 (29%)	1,404,754	1,782,554	377,800
	1924	**213 (32%)**	**2,175,515**	**2,665,876**	**490,361**

TABLE 11.

TOTAL RECEIPTS AND TOTAL EXPENDITURE OF GENERAL AND SPECIAL HOSPITALS SHOWN SEPARATELY.

Hospitals.	No. of Hospitals.	Available Beds.	Total Receipts.	Total Expenditure.	Surplus.
General Hospitals—					
Group A	102	19,561	£ 3,423,926	£ 3,300,783	£ 123,143
Group B	139	6,937	1,110,828	1,006,391	104,437
Group C	318	4,659	731,129	620,698	110,431
Total	**559**	**31,157**	**£ 5,265,883**	**£ 4,927,872**	**£ 338,011**
Special Hospitals—					
Group A	12	2,063	£ 289,165	£ 256,048	£ 33,117
Group B	58	3,021	547,572	468,792	78,780
Group C	33	590	93,229	89,994	3,235
Total	**103**	**5,674**	**£ 929,966**	**£ 814,834**	**£ 115,132**

TABLE 12.

ORDINARY INCOME AND EXPENDITURE.

Hospitals.	Year.	No. of Hospitals.	Total Ordinary Income.	Total Ordinary Expenditure.	Deficit.	Surplus.
Group A ...	1920	107	£ 2,510,968	£ 2,959,029	£ 448,061	—
	1921	108	2,599,892	2,956,763	356,871	—
	1922	109	2,684,704	2,799,135	114,431	—
	1923	115	3,008,120	2,866,375	—	£ 141,745
	1924	**114**	**2,823,945**	**2,912,158**	**88,213**	—
Group B	1920	164	967,826	1,005,608	37,782	—
	1921	164	986,302	1,002,402	16,100	—
	1922	164	992,829	942,003	—	50,826
	1923	184	1,085,000	999,279	—	85,721
	1924	**197**	**1,130,204**	**1,080,533**	—	**49,671**
Group C ...	1920	301	494,149	471,262	—	22,887
	1921	309	507,583	484,541	—	23,042
	1922	314	497,878	462,358	—	35,520
	1923	325	527,649	485,403	—	42,246
	1924	**351**	**586,518**	**533,491**	—	**53,027**
Total ...	1920	572	£ 3,972,943	£ 4,435,899	£ 462,956	—
	1921	581	4,093,777	4,443,706	349,929	—
	1922	587	4,175,411	4,203,496	28,085	—
	1923	624	4,620,769	4,351,057	—	£ 269,712
	1924	**662**	**4,540,667**	**4,526,182**	—	**14,485**

TABLE 13.

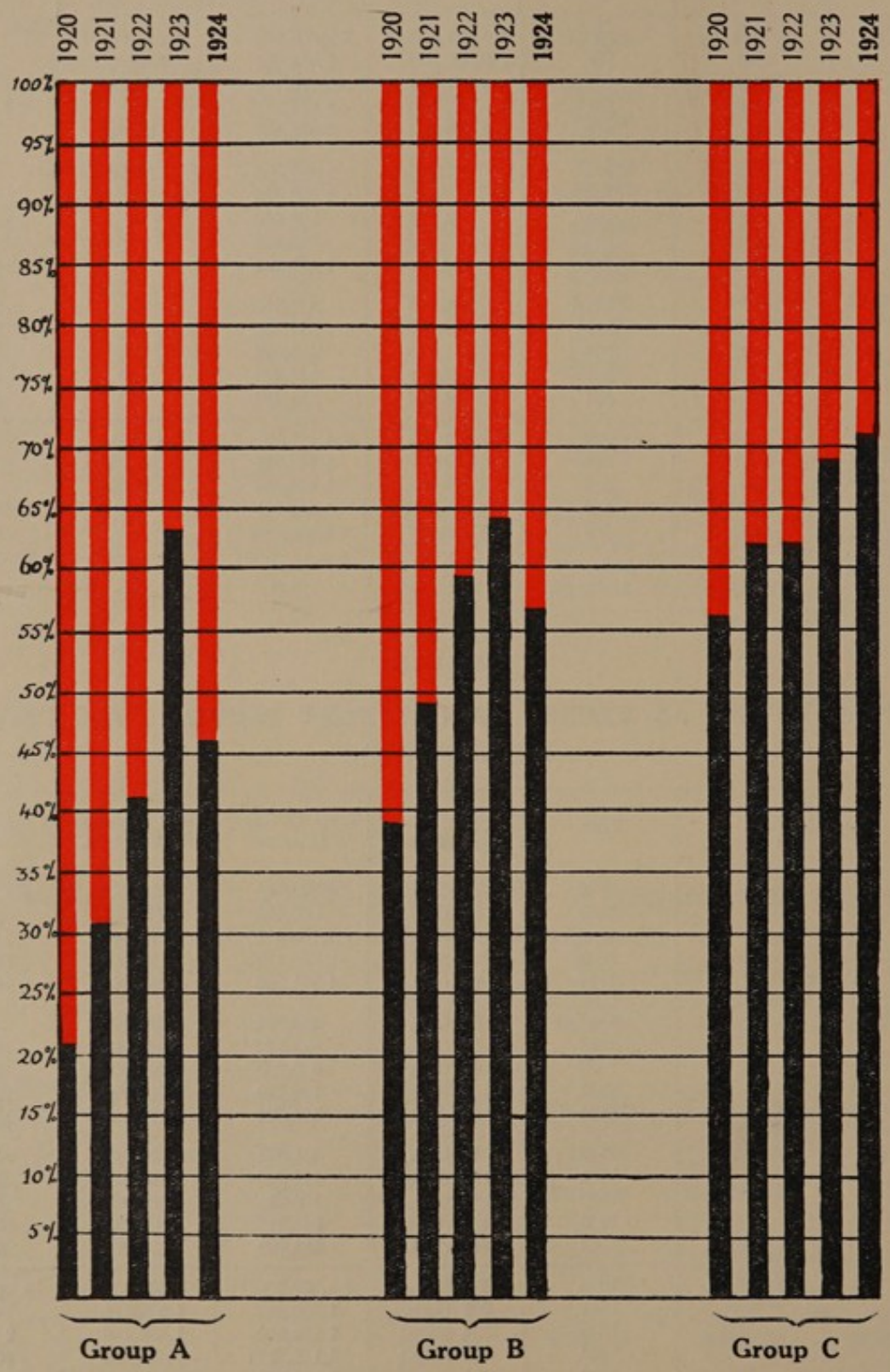
HOSPITALS HAVING AN **EXCESS OF ORDINARY INCOME** OVER ORDINARY EXPENDITURE.

Hospitals.	Year.	No. of Hospitals.	Total Ordinary Income.	Total Ordinary Expenditure.	Surplus.
Group A	1920	23 (21%)	£ 694,334	£ 583,479	£ 110,855
	1921	33 (31%)	855,463	774,583	80,880
	1922	45 (41%)	1,139,441	998,962	140,479
	1923	73 (63%)	2,005,179	1,723,692	281,487
	1924	**52 (46%)**	**1,251,006**	**1,104,094**	**146,912**
Group B	1920	64 (39%)	423,599	362,103	61,496
	1921	81 (49%)	514,732	448,963	65,769
	1922	96 (59%)	638,788	544,553	94,235
	1923	118 (64%)	728,719	603,193	125,526
	1924	**112 (57%)**	**682,450**	**579,110**	**103,340**
Group C	1920	168 (56%)	281,274	234,742	46,532
	1921	192 (62%)	318,245	268,566	49,679
	1922	195 (62%)	336,431	282,985	53,446
	1923	224 (69%)	385,712	327,715	57,997
	1924	**248 (71%)**	**455,909**	**389,961**	**65,948**
Total	1920	255 (45%)	£ 1,399,207	£ 1,180,324	£ 218,883
	1921	306 (53%)	1,688,440	1,492,112	196,328
	1922	336 (57%)	2,114,660	1,826,500	288,160
	1923	415 (67%)	3,119,610	2,654,600	465,010
	1924	**412 (62%)**	**2,389,365**	**2,073,165**	**316,200**

PERCENTAGE OF HOSPITALS HAVING AN EXCESS OF:—

ORDINARY INCOME ... ... Shown in Black.

ORDINARY EXPENDITURE ... Shown in Red.



Illustrating Tables 13 and 14.

TABLE 14.

HOSPITALS HAVING AN **EXCESS OF ORDINARY EXPENDITURE** OVER ORDINARY INCOME.

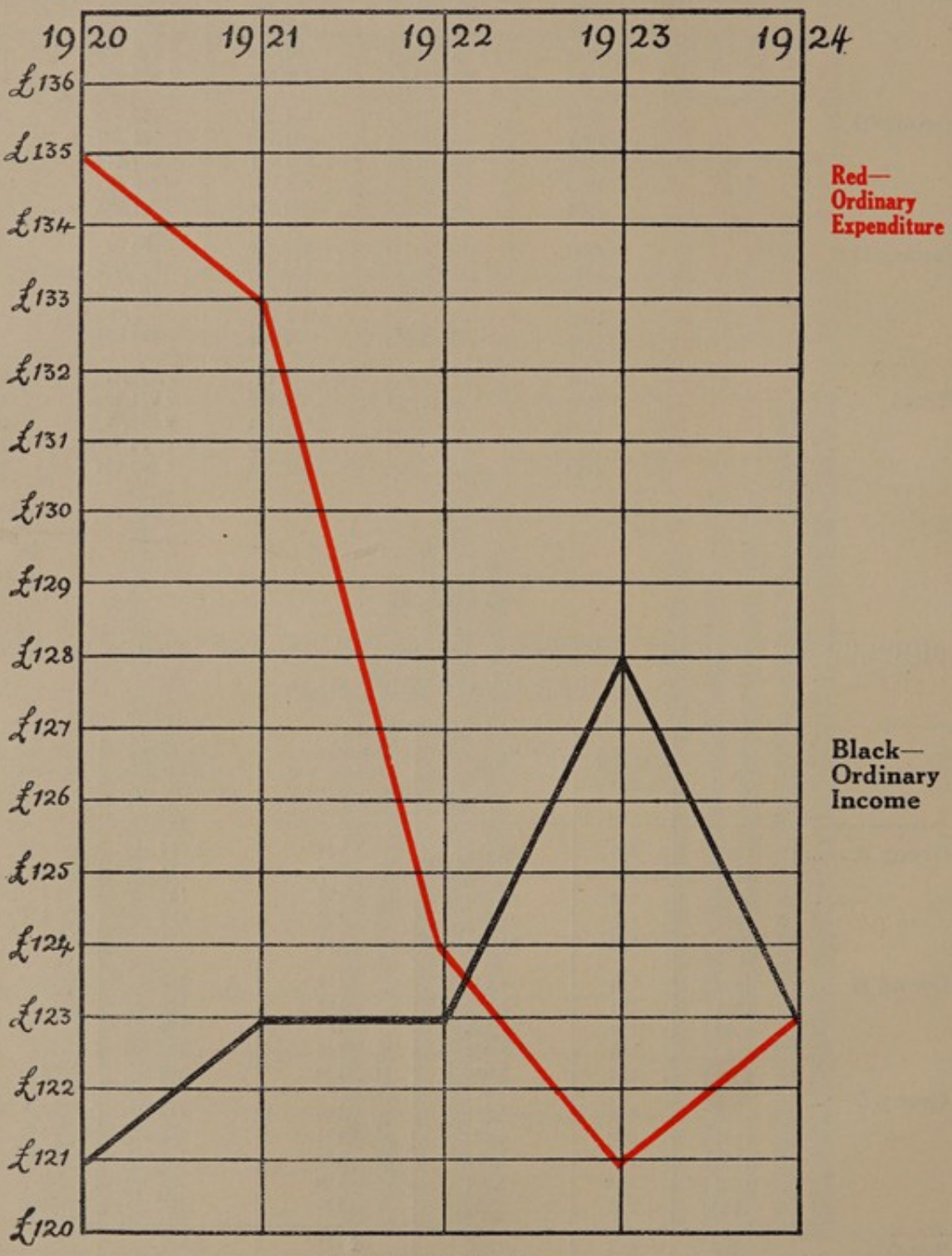
Hospitals.	Year.	No. of Hospitals.	Total Ordinary Income.	Total Ordinary Expenditure.	Deficit.
Group A	1920	84 (79%)	£ 1,816,634	£ 2,375,550	£ 558,916
	1921	75 (69%)	1,744,429	2,182,180	437,751
	1922	64 (59%)	1,545,263	1,800,173	254,910
	1923	42 (37%)	1,002,941	1,142,683	139,742
	1924	**62 (54%)**	**1,572,939**	**1,808,064**	**235,125**
Group B	1920	100 (61%)	544,227	643,505	99,278
	1921	83 (51%)	471,570	553,439	81,869
	1922	68 (41%)	354,041	397,450	43,409
	1923	66 (36%)	356,281	396,086	39,805
	1924	**85 (43%)**	**447,754**	**501,423**	**53,669**
Group C ...	1920	133 (44%)	212,875	236,520	23,645
	1921	117 (38%)	189,338	215,975	26,637
	1922	119 (38%)	161,447	179,373	17,926
	1923	101 (31%)	141,937	157,688	15,751
	1924	**103 (29%)**	**130,609**	**143,530**	**12,921**
Total	1920	317 (55%)	£ 2,573,736	£ 3,255,575	£ 681,839
	1921	275 (47%)	2,405,337	2,951,594	546,257
	1922	251 (43%)	2,060,751	2,376,996	316,245
	1923	209 (33%)	1,501,159	1,696,457	195,298
	1924	**250 (38%)**	**2,151,302**	**2,453,017**	**301,715**

TABLE 15.

SURPLUS OR DEFICIT BETWEEN ORDINARY INCOME AND EXPENDITURE PER AVAILABLE BED.

Hospitals.	Year.	No. of Hospitals.	No. of available beds.	Ordinary Income per available bed.	Ordinary Expenditure per available bed.	Surplus.	Deficit.
Group A ...	1920	107	20,184	£ 124	£ 147	—	£ 23
	1921	108	20,525	127	144	—	17
	1922	109	20,960	128	134	—	6
	1923	115	22,071	136	130	£ 6	—
	1924	**114**	**21,624**	**131**	**135**	—	**4**
Group B ...	1920	164	8,437	115	119	—	4
	1921	164	8,363	118	120	—	2
	1922	164	8,436	118	112	6	—
	1923	184	9,206	118	109	9	-
	1924	**197**	**9,958**	**113**	**109**	**4**	—
Group C ...	1920	301	4,271	116	110	6	—
	1921	309	4,468	114	108	6	—
	1922	314	4,572	109	101	8	—
	1923	325	4,801	110	101	9	—
	1924	**351**	**5,249**	**112**	**102**	**10**	—
Total	1920	572	32,892	£ 121	£ 135	—	£ 14
	1921	581	33,356	123	133	—	10
	1922	587	33,968	123	124	—	1
	1923	624	36,078	128	121	£ 7	—
	1924	**662**	**36,831**	**123**	**123**	—	—

ORDINARY INCOME AND ORDINARY EXPENDITURE PER AVAILABLE BED OF THE TOTAL NUMBER OF HOSPITALS REVIEWED.



Illustrating Table 15.

TABLE 16.

ORDINARY INCOME AND ORDINARY EXPENDITURE OF GENERAL AND SPECIAL HOSPITALS SHOWN SEPARATELY.

Hospitals.	No. of Hospitals.	Available beds.	Ordinary Income.		Ordinary Expenditure.		Surplus per available bed.	Deficit per available bed.
			Total.	Per available bed.	Total.	Per available bed.		
General Hospitals—								
Group A	102	19,561	£ 2,613,621	£ 134	£ 2,693,162	£ 138	—	£ 4
,, B	139	6,937	767,431	111	722,266	104	£ 7	—
,, C	318	4,659	506,518	109	456,823	98	11	—
Total	**559**	**31,157**	**£ 3,887,570**	**£ 125**	**£ 3,872,251**	**£ 124**	**£ 1**	—
Special Hospitals—								
Group A	12	2,063	£ 210,324	£ 102	£ 218,996	£ 106	—	£ 4
,, B	58	3,021	362,773	120	358,267	119	£ 1	—
,, C	33	590	80,000	136	76,668	130	6	—
Total	**103**	**5,674**	**£ 653,097**	**£ 115**	**£ 653,931**	**£ 115**	—	—

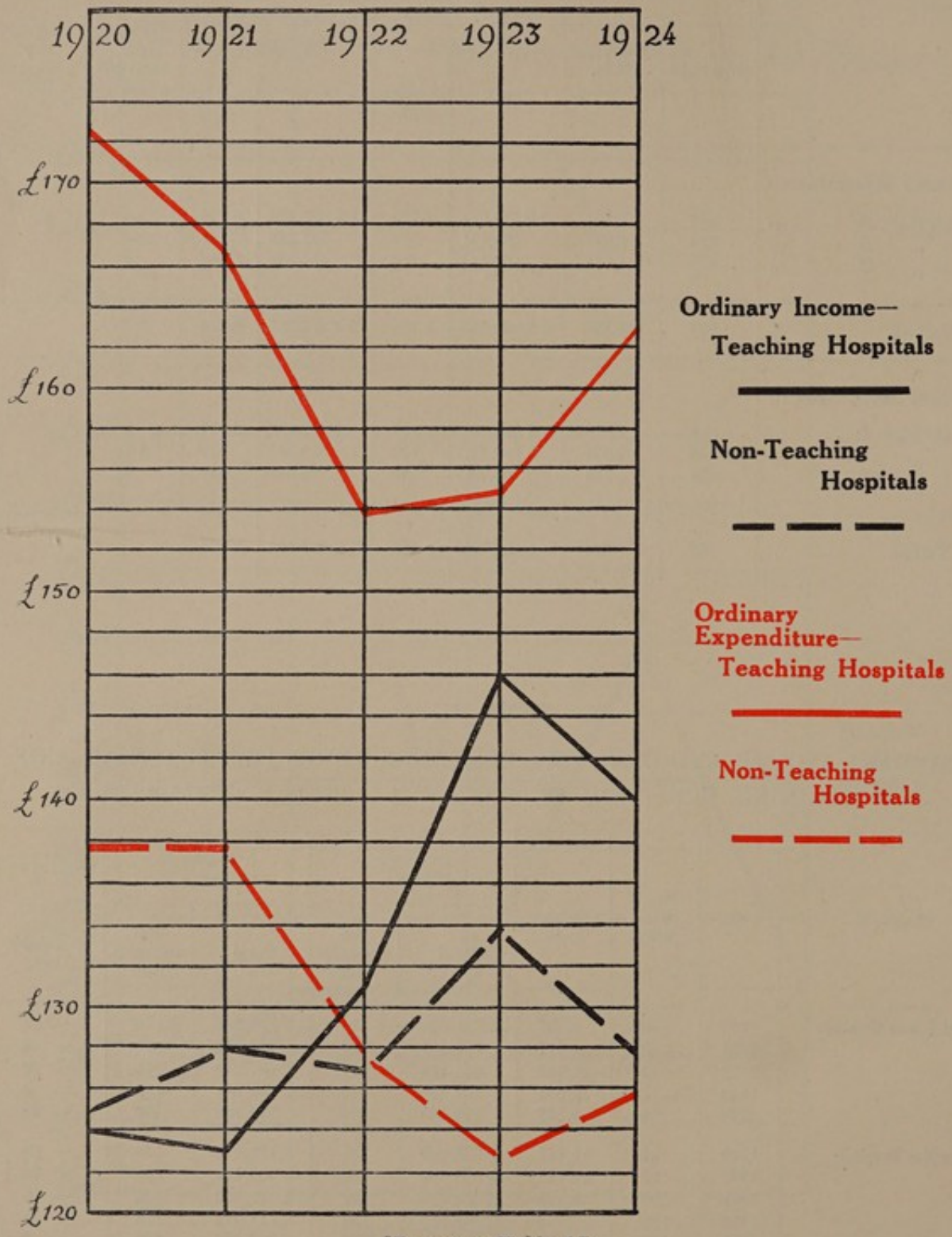
TABLE 17.

ORDINARY INCOME AND ORDINARY EXPENDITURE OF THE TEACHING AND NON-TEACHING HOSPITALS IN GROUP "A" SHOWN SEPARATELY.

Hospitals.	Year.	No. of Hospitals.	No. of available beds.	Ordinary Income.		Ordinary Expenditure.		Surplus (+) or Deficit (—) per *available* bed.
				Total.	Per *available* bed.	Total.	Per *available* bed.	
Medical School Hospitals	1920	13	4,467	£ 551,899	£ 124*	£ 784,997	£ 173*	—£ 49*
	1921	13	4,477	549,800	123	748,033	167	— 44
	1922	13	4,465	584,989	131	687,375	154	— 23
	1923	14	4,861	709,542	146	754,391	155	— 9
	1924	**14**	**4,857**	**679,881**	**140**	**792,522**	**163**	**— 23**
Non-teaching Hospitals	1920	94	15,717	1,959,069	125	2,174,032	138	— 13
	1921	95	16,048	2,050,092	128	2,208,730	138	— 10
	1922	96	16,495	2,099,715	127	2,111,760	128	— 1
	1923	101	17,210	2,298,578	134	2,111,984	123	+ 11
	1924	**100**	**16,767**	**2,144,064**	**128**	**2,119,636**	**126**	**+ 2**

* Calculated to the nearest £.

ORDINARY INCOME AND EXPENDITURE PER AVAILABLE BED OF HOSPITALS CONSTITUTING GROUP A.



Illustrating Table 17.

TABLE 18.

ORDINARY INCOME AND EXPENDITURE OF THE 14 HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN ENGLAND & WALES.

Hospitals.	Year.	Ordinary Income.	Ordinary Expenditure.	Ordinary Income per *occupied* bed.	Ordinary Expenditure per *occupied* bed.	Per *occupied* bed.	
						Deficit.	Surplus.
A	1920	£ 33,976	£ 52,436	£ 127·25	£ 196·38	£ 69·13	—
	1921	36,136	50,194	138·98	193·05	54·07	—
	1922	33,529	46,686	122·55	170·64	48·09	—
	1923	37,630	45,783	134·12	163·18	29·06	—
	1924	**38,143**	**44,687**	**137·64**	**161·26**	**23·62**	—
B	1920	24,361	36,983	140·00	214·84	74·84	—
	1921	23,389	36,844	135·84	213·99	78·15	—
	1922	24,640	34,902	135·50	191·93	56·43	—
	1923	24,468	33,527	129·10	176·92	47·82	—
	1924	**26,041**	**36,608**	**130·28**	**183·15**	**52·87**	—
C	1920	54,684	80,978	163·23	241·72	78·49	—
	1921	56,898	75,754	179·49	238·97	59·48	—
	1922	60,613	61,132	204·08	205·83	1·75	—
	1923	58,264	66,687	185·55	212·38	26·83	—
	1924	**59,374**	**69,955**	**186·71**	**219·98**	**33·27**	—
D	1920	23,927	40,417	131·46	222·07	90·61	—
	1921	28,108	34,195	157·18	191·25	34·07	—
	1922	29,118	33,822	161·05	187·07	26·02	—
	1923	28,659	34,519	157·73	181·00	23·27	—
	1924	**29,119**	**35,740**	**156·72**	**192·36**	**35·64**	—
E	1920	31,260	52,874	100·83	170·56	69·73	—
	1921	32,129	51,589	95·91	154·00	58·09	—
	1922	43,340	46,038	127·10	135·01	7·91	—
	1923	56,220	50,076	160·17	142·66	—	£ 17·51
	1924	**49,078**	**53,694**	**143·92**	**157·46**	**13·54**	—
F	1920	22,849	45,217	103·38	204·60	101·22	—
	1921	22,834	38,367	111·93	188·07	76·14	—
	1922	32,175	29,886	153·21	142·31	—	10·90
	1923	39,396	37,286	168·36	159·34	—	9·02
	1924	**38,316**	**45,601**	**139·84**	**166·43**	**26·59**	—
G	1920	27,209	60,206	111·05	245·73	134·68	—
	1921	43,144	51,242	160·39	190·49	30·10	—
	1922	40,629	50,010	147·42	181·46	34·04	—
	1923	44,740	53,317	155·51	185·32	29·81	—
	1924	**42,716**	**61,387**	**142·39**	**204·62**	**62·23**	—
H	1920	25,912	44,768	112·66	194·64	81·98	—
	1921	24,249	42,703	104·39	183·83	79·44	—
	1922	32,450	37,538	135·69	156·96	21·27	—
	1923	30,028	37,570	124·14	155·32	31·18	—
	1924	**30,525**	**42,065**	**124·46**	**171·52**	**47·06**	—
I	1920	83,737	105,354	154·21	195·86	41·65	—
	1921	75,882	100,981	143·44	190·89	47·45	—
	1922	77,263	100,541	147·32	191·67	44·35	—
	1923	96,134	98,130	177·70	181·39	3·69	—
	1924	**79,906**	**101,881**	**148·25**	**189·02**	**40·77**	—
J	1920	66,932	99,192	171·62	254·34	82·72	—
	1921	45,605	95,025	106·31	221·50	115·19	—
	1922	62,685	90,723	140·87	203·87	63·00	—
	1923	73,335	91 161	159·08	197·75	38·67	—
	1924	**69,753**	**87,744**	**149·36**	**187·89**	**38·53**	—
K	1920	112,699	108,389	221·84	213·36	—	8·48
	1921	96,788	103,841	188·82	202·58	13·76	—
	1922	89,960	91,555	171·22	174·26	3·04	—
	1923	92,180	87,795	171·53	163·37	—	8·16
	1924	**91,785**	**88,817**	**170·30**	**164·78**	—	**5·52**

TABLE 18.—*continued.*

Hospitals.	Year.	Ordinary Income.	Ordinary Expenditure.	Ordinary Income per *occupied* bed.	Ordinary Expenditure per *occupied* bed.	Per *occupied* bed.	
						Deficit.	Surplus.
L	1920	£ 21,756	£ 33,733	£ 123·61	£ 191·66	£ 68·05	—
	1921	40,917	39,349	235·15	226·14	—	£ 9·01
	1922	35,333	39,991	200·76	227.22	26·46	—
	1923	37,943	37,130	224·51	219·70	—	4·81
	1924	**40,032**	**37,661**	**232 74**	**218·96**	—	**13·78**
M	1920	22,597	24,450	159·13	172·18	13·05	—
	1921	23,721	27,949	145·53	171·47	25·94	—
	1922	23,254	24,551	122·39	129·32	6·93	—
	1923	23,464	23,996	131·08	134·06	2·98	—
	1924	**22,941**	**24,169**	**131·84**	**138·90**	**7·06**	—
*N	1923	67,081	57,414	210·55	180·21	—	30·34
	1924	**62,152**	**62,522**	**191·95**	**193·09**	**1·14**	—
Totals ...	1920	£ 551,899	£ 784,997	£ 148·15	£ 210·73	£ 62·58	—
	1921	549,800	748,033	145·60	198·10	52·50	—
	1922	584,989	687,375	152·42	179·10	26·68	—
	1923	709,542	754,391	165·55	176·01	10·46	—
	1924	**679,881**	**792,522**	**156·08**	**181·94**	**25·86**	—

* Recognised as a Medical School during 1923.

SECTION 3.

ANALYSIS OF SOME OF THE SOURCES OF ORDINARY INCOME OF THE VOLUNTARY HOSPITALS IN ENGLAND AND WALES.

INVESTED FUNDS.

The following Table gives the methods at present employed by the various Hospitals for the purpose of showing the amount of their Invested Funds :—

Hospitals.	Investments shown at Market Value.	Investments shown at Cost.	Investments shown at Nominal Value.	Basis not stated and Hospitals using more than one way.
Group A	39 = 34%	36 = 32%	13 = 11%	26 = 23%
Group B	38 = 19%	64 = 32%	37 = 19%	58 = 30%
Group C	62 = 18%	76 = 22%	104 = 29%	109 = 31%

These figures show such slight variations from the corresponding figures for the year 1923 that any comment thereon is unnecessary.

Probably the most convincing sign of the financial vigour of the Voluntary Hospitals is to be found in Table 19, which gives the Invested Funds and the Interest arising therefrom during the past five years. It is somewhat difficult to assess the extent to which the lower rate of Interest obtainable during 1924 as compared with 1920 affects the figures. The most important point, however, is that the total Invested Funds have risen more than £3,500,000 during the four-year period.

WORKMEN'S CONTRIBUTIONS.

The noteworthy feature is an increase all along the line. Particular attention is drawn to Group A where the amount per available bed has increased from £27.90 in 1920 to £40.45 in 1924, an increase of approximately 50 per cent.

PATIENTS' CONTRIBUTIONS.

This item of Hospital Income also shows increases all along the line.

INCOME FROM PUBLIC SERVICES.

The figures for 1924 show considerable decline from those of 1923 due to the exclusion from the Report of certain Hospitals referred to on page 9. If we add to the figures for 1924 the sums of money received by these excluded Hospitals during the year the results for the two years would be approximately the same.

The payments made in respect of Venereal Diseases continue to fall and are now approximately 15 per cent. lower than they were in 1920.

It is unfortunate that so large an amount as £55,141 has to be placed under the heading " Details not given."

SUBSCRIPTIONS AND DONATIONS.

The steady maintenance of subscriptions is a very remarkable testimony to the hold which the Hospitals have on those who have less to give than formerly.

CONGREGATIONAL COLLECTIONS.

Congregational collections, as can be seen from Table 26, produce year by year an almost similar amount.

INCOME OF MEDICAL SCHOOL HOSPITALS.

Table 27 analyses the sources of Ordinary Income of the fourteen Hospitals associated with Medical Schools. In this group Interest from Investments has increased from £84,216 for the year 1920 to £106,603 for the year 1924, an increase of over £22,000 per annum. Similarly Patients' Contributions over the same period have increased from £25,552 to £72,339, an increase of approximately £47,000 per annum. The most striking increase, however, is under the heading "Workmen's Contributions," amounting as they did in 1920 to £129,498 and in 1924 to £225,594, an increase of over £96,000 per annum.

The income from Public Services shows a decrease mainly due to the reduction in the amount derived from the War Office and the Ministry of Pensions for the treatment of ex-Service men.

THE HOSPITAL BUDGET.

Taken as a whole the Hospitals have to find each year approximately £123 per available bed (the Medical School Hospitals have to find considerably more, viz., £163 per available bed).

The following Table shows the extent to which Hospital Committees, at the beginning of each financial year, may reasonably rely upon certain sources of Income:—

	Hospitals as a Whole.	*Medical School Group.*
From Investments	£19 per available bed	£22 per available bed.
,, Free Gifts	41	42
,, Workmen's Contributions and Contributory Schemes	34	46
,, Payments by or on behalf of Patients	28	29
	£122	£139

TABLE 19.

INVESTED FUNDS AND THE INTEREST THEREFROM.

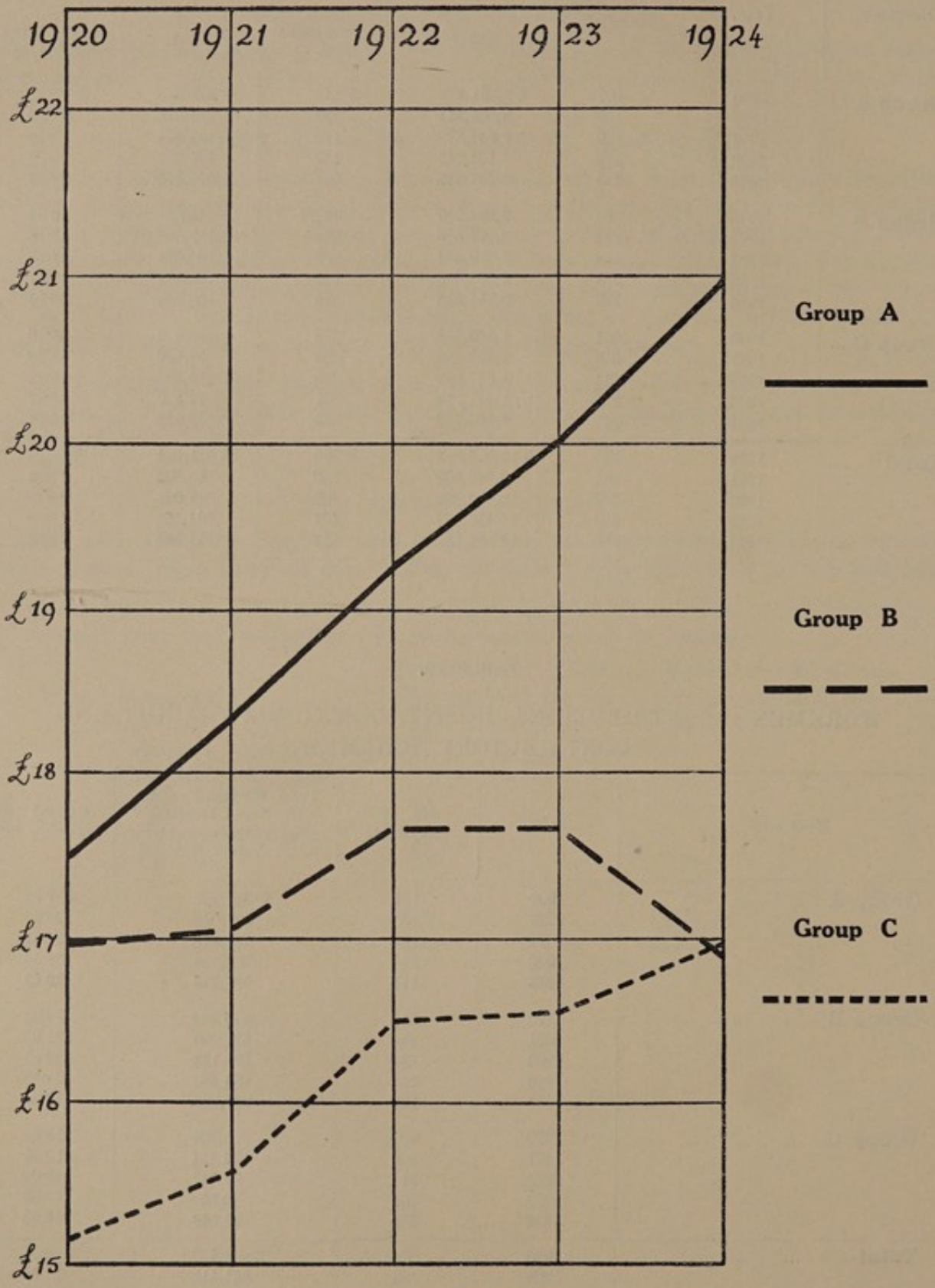
Hospitals.	Year.	No. of Hospitals.	Invested Funds.		Interest from Investments.	
			Total.	Per available bed.	Total.	Amount per available bed.
Group A ...	1920	107	£ 7,361,452	£ 365	£ 353,310	£ 17·50
	1921	108	8,005,811	390	376,278	18·33
	1922	109	8,645,372	412	403,454	19·24
	1923	115	9,121,016	413	441,887	20·02
	1924	**114**	**9,321,619**	**431**	**453,866**	**20·99**
Group B ...	1920	164	2,964,987	351	143,364	16·99
	1921	164	3,295,386	394	142,678	17·06
	1922	164	3,378,364	400	149,034	17·66
	1923	184	3,605,286	392	162,694	17·67
	1924	**197**	**3,741,395**	**376**	**168,336**	**16·90**
Group C ...	1920	301	1,189,418	278	64,870	15·18
	1921	309	1,497,496	335	69,670	15·59
	1922	314	1,627,087	356	75,563	16·52
	1923	325	1,731,972	361	79,572	16·57
	1924	**351**	**1,966,744**	**375**	**89,051**	**16·97**
Total ...	1920	572	£ 11,515,857	£ 350	£ 561,544	£ 17·09
	1921	581	12,798,693	383	588,626	17·64
	1922	587	13,650,823	402	628,051	18·48
	1923	624	14,458,274	401	684,153	18·96
	1924	**662**	**15,029,758**	**408**	**711,253**	**19·31**

TABLE 20.

WORKMEN'S CONTRIBUTIONS, HOSPITAL SATURDAY FUNDS AND CONTRIBUTORY SCHEMES.

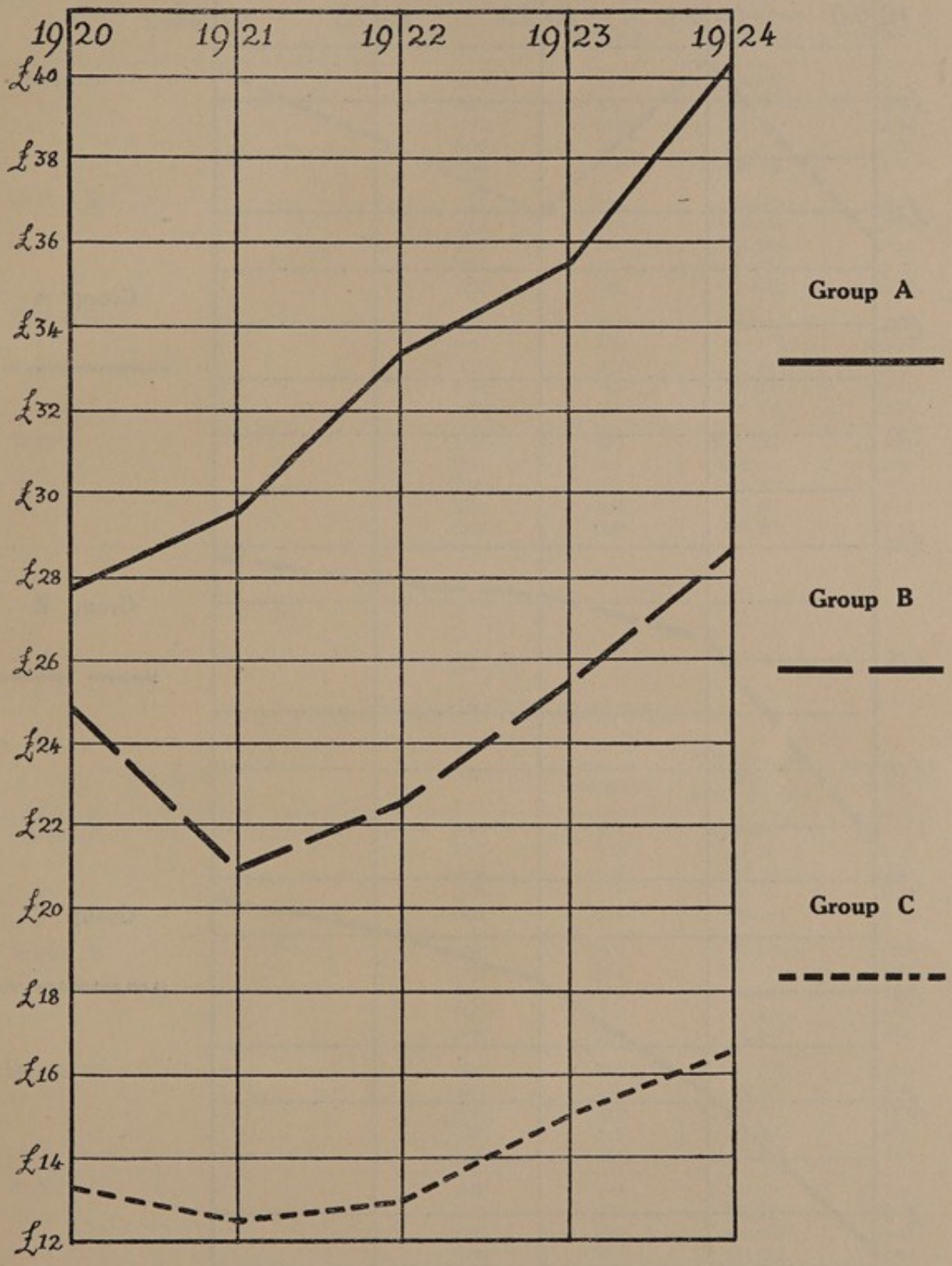
Hospitals.	Year.	No. of Hospitals.	Total Workmen's Contributions, Hospital Saturday Funds and Contributory Schemes,	Amount per available bed.
Group A	1920	107	£ 563,257	£ 27·90
	1921	108	609,094	29·67
	1922	109	701,673	33·47
	1923	115	784,983	35·56
	1924	**114**	**874,714**	**40·45**
Group B	1920	164	210,548	24·95
	1921	164	176,206	21·06
	1922	164	191,153	22·65
	1923	184	235,581	25·58
	1924	**197**	**287,393**	**28·86**
Group C	1920	301	56,728	13·28
	1921	309	56,111	12·55
	1922	314	59,547	13·02
	1923	325	72,058	15·00
	1924	**351**	**87,046**	**16·58**
Total	1920	572	£ 830,533	£ 25·25
	1921	581	841,411	25·22
	1922	587	952,373	28·03
	1923	624	1,092,622	30·28
	1924	**662**	**1,249,153**	**33·91**

AMOUNT PER AVAILABLE BED DERIVED FROM INTEREST ON INVESTMENTS.



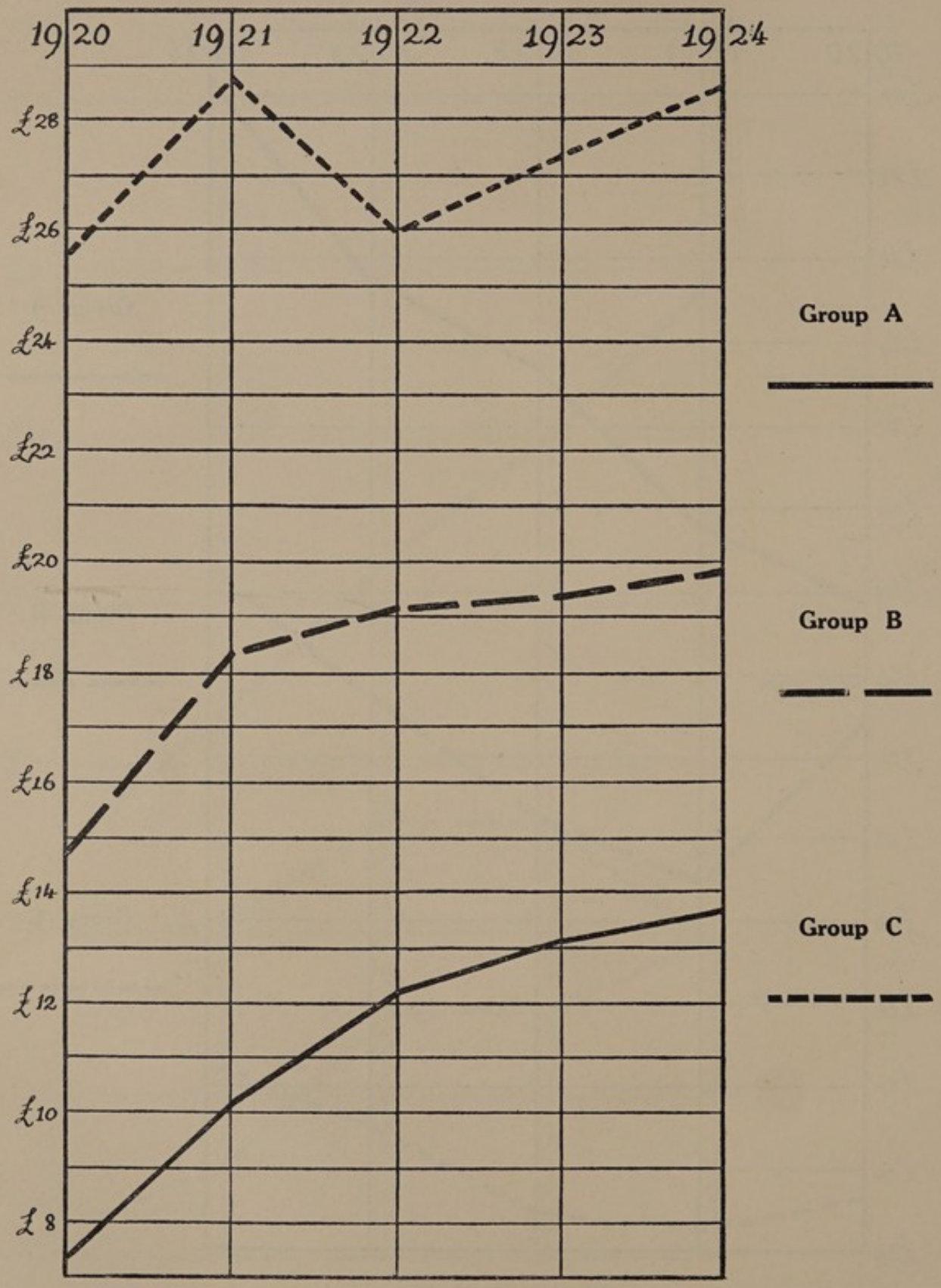
Illustrating Table 19.

AMOUNT PER AVAILABLE BED DERIVED FROM WORKMEN'S CONTRIBUTIONS AND CONTRIBUTORY SCHEMES.



Illustrating Table 20.

AMOUNT PER AVAILABLE BED DERIVED FROM PATIENTS' CONTRIBUTIONS.



Illustrating Table 21.

TABLE 21.

PATIENTS' CONTRIBUTIONS (including donations from "Grateful Patients.")

Hospital.	Year.	No. of Hospitals.	Total Patients' Contributions.	Amount per available bed.
Group A	1920	107	£ 149,508	£ 7·40
	1921	108	209,396	10·20
	1922	109	256,175	12·22
	1923	115	291,617	13·21
	1924	**114**	**296,146**	**13·70**
Group B	1920	164	125,099	14·82
	1921	164	153,750	18·38
	1922	164	161,505	19·14
	1923	184	178,514	19·39
	1924	**197**	**197,655**	**19·85**
Group C	1920	301	109,646	25·67
	1921	309	128,876	28·83
	1922	314	118,949	26·01
	1923	325	131,806	27·41
	1924	**351**	**150,413**	**28·66**
Total	1920	572	£ 384,253	£ 11·68
	1921	581	492,022	14·75
	1922	587	536,629	15·79
	1923	624	601,937	16·67
	1924	**662**	**644,214**	**17·49**

TABLE 22.

INCOME FROM PUBLIC SERVICES.

Hospitals.	Year.	No. of Hospitals.	Total Income from Public Services.	Amount per available bed.
Group A	1920	107	£ 436,269	£ 21·61
	1921	108	440,760	21·47
	1922	109	397,189	17·99
	1923	115	400,954	18·16
	1924	**114**	**289,718**	**13·40**
Group B	1920	164	116,981	13·86
	1921	164	105,176	12·57
	1922	164	83,169	9·85
	1923	184	80,964	8·79
	1924	**197**	**78,689**	**7·90**
Group C	1920	301	17,075	3·99
	1921	309	16,972	3·79
	1922	314	12,505	2·73
	1923	325	12,345	2·57
	1924	**351**	**10,273**	**1·96**
Total	1920	572	£ 570,325	£ 17·35
	1921	581	562,908	16·87
	1922	587	492,863	14·53
	1923	624	494,263	13·69
	1924	**662**	**378,680**	**10·28**

TABLE 23.

ANALYSIS OF THE SOURCES OF INCOME FROM PUBLIC SERVICES.

Hospitals.	Year.	War Office or Admiralty.	Ministry of Pensions.	Infant Welfare and Maternity Work.	Venereal Diseases.	Tuber-culosis cases.	Education Authorities.	National Health Insurance Act.	Details not given.
Group A ...	1920	£ 9,957	£ 223,349	£ 3,011	£ 95,965	£ 11,365	£ 10,688	£ 28,200	£ 53,734
	1921	3,879	195,938	7,960	95,793	50,410	10,864	33,451	42,465
	1922	1,713	119,408	6,582	97,001	51,630	11,103	29,825	79,927
	1923	953	64,109	8,828	91,380	55,338	17,676	85,874	76,796
	1924	**1,207**	**31,880**	**11,086**	**89,158**	**28,868**	**8,519**	**84,202**	**34,798**
Group B ...	1920	1,390	60,530	10,553	19,066	4,547	3,668	8,699	8.528
	1921	1,019	41,034	17,045	17,717	10,143	4,002	5,937	8,279
	1922	197	23,340	13,970	13,319	14,599	3,801	1,994	11,949
	1923	86	11,010	20,599	11,641	11,461	3,231	10,384	12,552
	1924	**229**	**11,685**	**16,915**	**8,769**	**5,829**	**5,099**	**12,498**	**17,665**
Group C ...	1920	—	6,304	4,958	1,907	932	868	2,040	66
	1921	49	4,347	5,853	1,716	29	776	2,306	1,896
	1922	19	1,718	2,741	1,245	2,436	1,439	663	2,244
	1923	10	1,367	2,761	567	2,220	1,524	1,836	2,060
	1924	**2**	**760**	**2,375**	**586**	**25**	**1,662**	**2,185**	**2,678**
Total ...	1920	£ 11,347	£ 290,183	£ 18,522	£ 116,938	£ 16,844	£ 15,224	£ 38,939	£ 62,328
	1921	4,947	241,319	30,858	115,226	60,582	15,642	41,694	52,640
	1922	1,929	144,466	23,293	111,565	68,665	16,343	32,482	94,120
	1923	1,049	76,486	32,188	103,588	69,019	22,431	98,094	91,408
	1924	**1,438**	**44,325**	**30,376**	**98,513**	**34,722**	**15,280**	**98,885**	**55,141**

TABLE 24.

PAYMENT BY OR ON BEHALF OF PATIENTS.

Hospitals.	Year.	No. of Hospitals.	Total Payments by or on behalf of Patients.	Amount per available bed.
Group A	1920	107	£ 585,777	£ 29·02
	1921	108	650,156	31·67
	1922	109	653,364	31·17
	1923	115	692,063	31·35
	1924	**114**	**585,864**	**27·10**
Group B	1920	164	242,080	28·69
	1921	164	258,926	30·96
	1922	164	244,674	29·00
	1923	184	259,478	28·18
	1924	**197**	**276,344**	**27·75**
Group C	1920	301	126,721	29·67
	1921	309	145,848	32·64
	1922	314	131,454	28·53
	1923	325	144,151	30·02
	1924	**351**	**160,686**	**30·62**
Total	1920	572	£ 954,578	£ 29·02
	1921	581	1,054,930	31·62
	1922	587	1,029,492	30·30
	1923	624	1,095,692	30·37
	1924	**662**	**1,022,894**	**27·77**

TABLE 25.

INCOME DERIVED FROM SUBSCRIPTIONS AND DONATIONS.

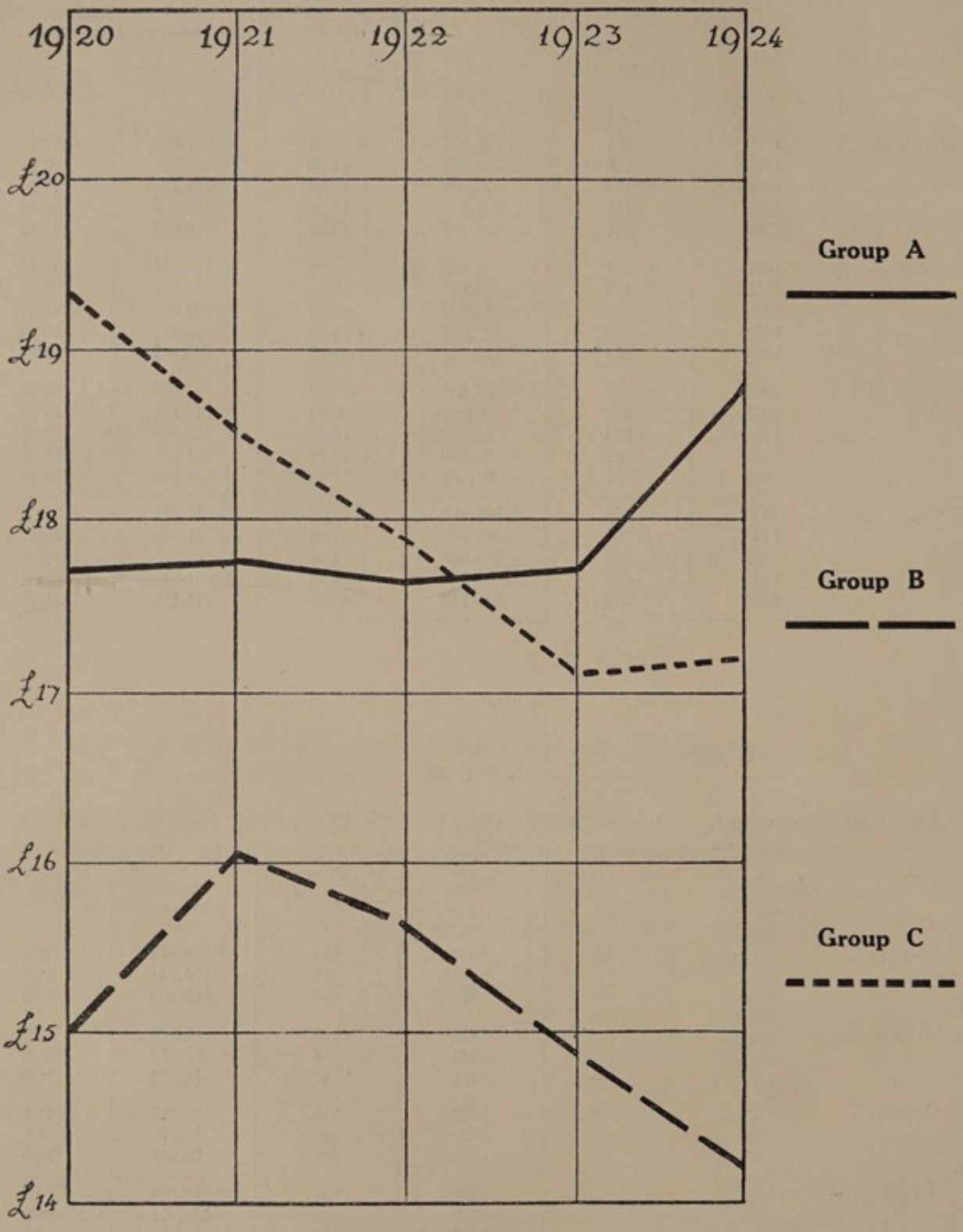
Hospitals.	Year.	No. of Hospitals.	Subscriptions.		Donations (including Entertainments, etc.).	
			Total.	Amount per available bed.	Total.	Amount per available bed.
Group A ...	1920	107	£ 358,059	£ 17·73	£ 351,892	£ 17·43
	1921	108	365,241	17·79	423,039	20·61
	1922	109	370,624	17·68	403,335	19·24
	1923	115	391,639	17·74	466,526	21·13
	1924	**114**	**406,119**	**18·79**	**379,448**	**17·55**
Group B ...	1920	164	126,822	15·03	123,526	14·64
	1921	164	134,484	16·08	200,811	24·01
	1922	164	131,995	15·64	189,144	22·42
	1923	184	137,282	14·90	245,103	26·62
	1924	**197**	**141,716**	**14·23**	**204,517**	**20·54**
Group C ...	1920	301	82,695	19·36	71,937	16·84
	1921	309	82,860	18·54	117,712	24·10
	1922	314	81,847	17·90	126,022	27·56
	1923	325	82,209	17·12	124,624	25·93
	1924	**351**	**90,368**	**17·22**	**135,288**	**25·77**
Total ...	1920	572	£ 567,576	£ 17·27	£ 547,355	£ 16·64
	1921	581	582,585	17·46	741,562	22·23
	1922	587	584,466	17·20	718,501	21·15
	1923	624	611,130	16·93	836,253	23·17
	1924	**662**	**638,203**	**17·33**	**719,253**	**19·53**

TABLE 26.

CONGREGATIONAL COLLECTIONS, INCLUDING HOSPITAL SUNDAY FUNDS.

Hospitals.	Year.	No. of Hospitals.	Total Congregational Collections, etc.	Amount per available bed.
Group A	1922	109	£ 102,342	£ 4·88
	1923	115	106,741	4·83
	1924	**114**	**110,364**	**5·10**
Group B	1922	164	36,379	4·31
	1923	184	37,032	4·02
	1924	**197**	**35,374**	**3·55**
Group C	1922	314	19,745	4·31
	1923	325	19,598	4·08
	1924	**351**	**20,763**	**3·96**
Total	1922	587	£ 158,466	£ 4·68
	1923	624	163,371	4·52
	1924	**662**	**166,501**	**4·52**

AMOUNT PER AVAILABLE BED DERIVED FROM ANNUAL SUBSCRIPTIONS.



Illustrating Table 25.

TABLE 27.

SOME OF THE SOURCES OF ORDINARY INCOME OF THE 14 HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN ENGLAND AND WALES.

Hospitals.	Year.	Interest on Investments.	Workmen's Contributions, Hospital Saturday Funds and Contributory Schemes.	Patients' Contributions.	Income from Public Services.
A	1920	£ 6,551	£ 5,104	£ 5,546	£ 9,129
	1921	7,084	4,325	10,427	9,086
	1922	7,368	4,000	11,034	6,934
	1923	7,794	3,720	11,661	8,236
	1924	**7,735**	**4,280**	**12,465**	**7,032**
B	1920	3,428	3,871	4,423	6,100
	1921	3,363	3,323	6,974	4,841
	1922	4,019	3,262	6,563	4,866
	1923	3,687	3,006	7,035	4,907
	1924	**3,854**	**2,974**	**8,152**	**5,116**
C	1920	13,300	15,095	603	7,384
	1921	12,151	16,384	59	781
	1922	13,528	16,115	3,673	7,061
	1923	12,058	16,450	1,716	8,070
	1924	**12,706**	**17,328**	**1,802**	**7,537**
D	1920	4,391	8,469	717	511
	1921	4,402	6,000	2,486	898
	1922	4,597	7,744	2,744	2,195
	1923	4,572	8,153	2,348	2,721
	1924	**4,418**	**9,057**	**2,638**	**2,468**
E	1920	4,259	9,126	—	3,613
	1921	4,287	10,305	—	1,641
	1922	4,618	22,666	2,368	2,754
	1923	4,798	31,565	1,870	3,448
	1924	**4,888**	**33,190**	**1,399**	**3,119**
F	1920	2,689	4,714	202	5,819
	1921	2,916	7,330	210	848
	1922	3,210	16,418	2,369	2,234
	1923	3,441	21,441	1,855	2,730
	1924	**3,263**	**25,106**	**1,615**	**3,007**
G	1920	2,841	5,088	—	284
	1921	6,616	4,361	2,968	—
	1922	7,511	5,945	8,529	—
	1923	11,852	4,772	8,654	—
	1924	**13,219**	**4,590**	**8,739**	—
H	1920	6,075	4,845	352	575
	1921	5,318	4,258	3,794	339
	1922	5,056	5,374	8,050	1,447
	1923	4,896	5,099	5,940	3,797
	1924	**4,585**	**5,143**	**5,935**	**4,048**
I	1920	18,119	1,577	8,558	13,073
	1921	18,229	2,220	10,809	13,875
	1922	18,016	2,186	10,378	8,757
	1923	18,327	2,491	11,878	8,398
	1924	**17,711**	**4,013**	**12,719**	**7,503**
J	1920	6,996	24,918	2,449	10,453
	1921	6,953	25,242	3,284	8,960
	1922	5,754	27,992	3,511	7,708
	1923	10,891	30,392	3,748	6,856
	1924	**9,789**	**23,227**	**4,307**	**6,577**
K	1920	9,356	44,952	1,446	13,818
	1921	8,493	44,075	1,978	10,517
	1922	8,849	43,648	2,324	9,517
	1923	9,321	44,662	2,030	14,098
	1924	**10,034**	**45,783**	**1,959**	**11,190**

TABLE 27.—*continued.*

Hospitals.	Year.	Interest on Investments.	Workmen s Contributions, Hospital Saturday Funds and Contributory Schemes.	Patients' Contributions.	Income from Public Services.
L	1920	2,830	939	282	6,347
	1921	2,255	16,281	1,285	8,718
	1922	2,501	20,479	2,098	2,715
	1923	2,666	21,436	3,660	3,294
	1924	**2,637**	**23,387**	**4,480**	**3,057**
M	1920	3,381	800	974	7,380
	1921	3,584	1,321	884	6,837
	1922	3,467	1,779	986	6,488
	1923	3,773	1,824	952	6,175
	1924	**3,635**	**2,253**	**1,049**	**4,900**
N*	**1923**	**7,671**	**24,178**	**4,940**	**841**
	1924	**8,129**	**25,263**	**5,080**	**1,362**
Totals	1920	£ 84,216	£ 129,498	£ 25,552	£ 84,486
	1921	85,651	145,425	45,158	67,341
	1922	88,494	177,608	64,627	62,676
	1923	105,747	219,189	68,287	73,571
	1924	**106,603**	**225,594**	**72,339**	**66,916**

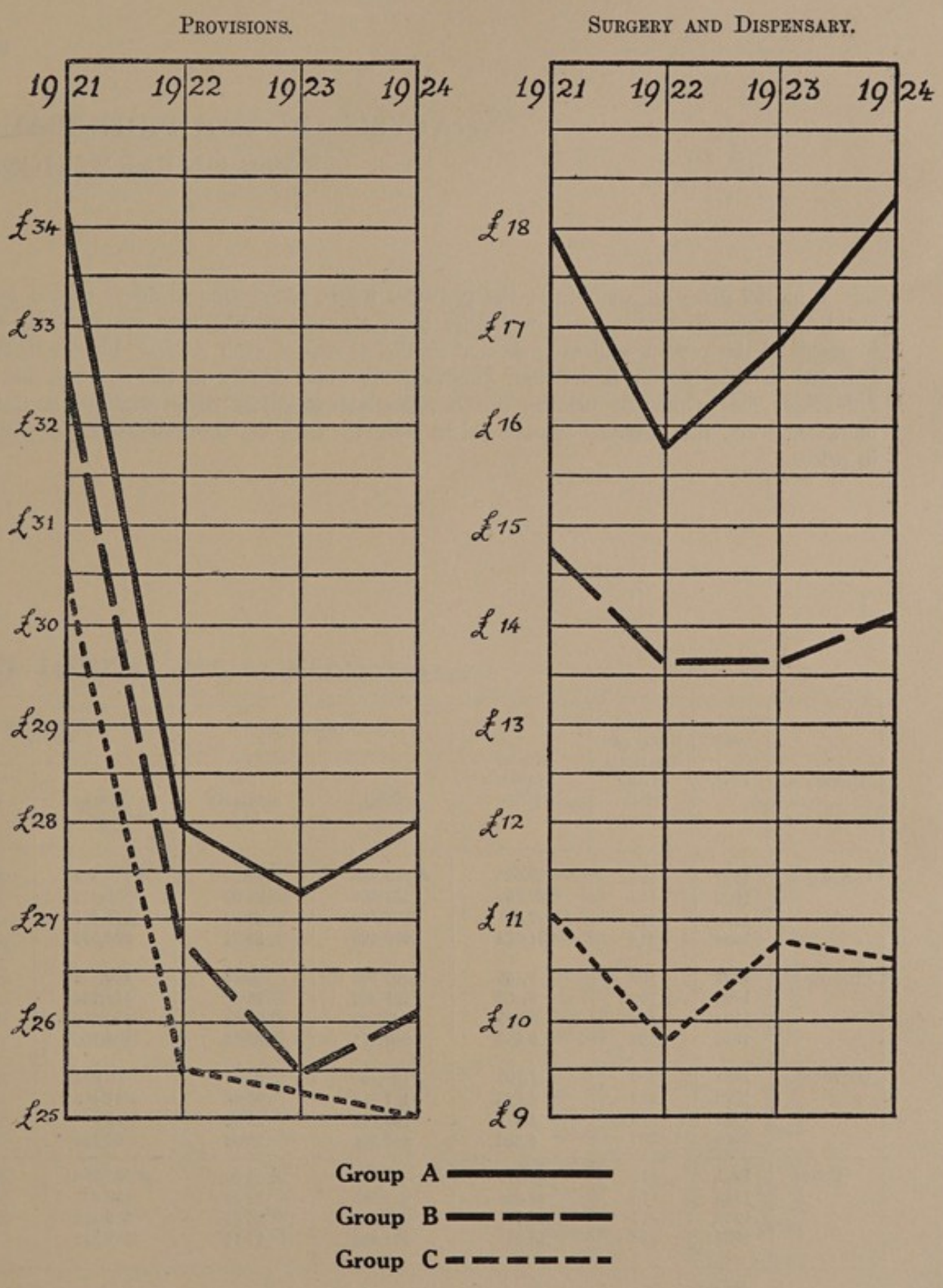
* Recognised as a Medical School during 1923.

TABLE 28.

SUMMARY OF ANALYSIS OF ORDINARY INCOME.

Hospitals.	Year.	No. of Hospitals.	Amount per available bed received from :—						
			Interest from Investments.	Workmen's Contributions, etc.	Patients' Contributions.	Income from Public Services.	Subscriptions.	Donations.	Total amount from the six sources.
Group A ...	1920	107	£ 17·50	£ 27·90	£ 7·40	£ 21·61	£ 17·73	£ 17·43	£ 109·57
	1921	108	18·33	29·67	10·20	21·47	17·79	20·61	118·07
	1922	109	19·24	33·47	12·22	17·99	17·68	19·24	119·84
	1923	115	20·02	35·56	13·21	18·16	17·74	21·13	125·82
	1924	**114**	**20·99**	**40·45**	**13·70**	**13·40**	**18·79**	**17·55**	**124·88**
Group B ...	1920	164	16·99	24·95	14·82	13·86	15·03	14·64	100·29
	1921	164	17·06	21·06	18·38	12·57	16·08	24·01	109·16
	1922	164	17·66	22·65	19·14	9·85	15·64	22·42	107·36
	1923	184	17·67	25·58	19·39	8·79	14·90	26·62	112·95
	1924	**197**	**16·90**	**28·86**	**19·85**	**7·90**	**14·23**	**20·54**	**108·28**
Group C ...	1920	301	15·18	13·28	25·67	3·99	19·36	16·84	94·32
	1921	309	15·59	12·55	28·83	3·79	18·54	24·10	103·40
	1922	314	16·52	13·02	26·01	2·73	17·90	27·56	103·74
	1923	325	16·57	15·00	27·41	2·57	17·12	25·93	104·60
	1924	**351**	**16·97**	**16·58**	**28·66**	**1·96**	**17·22**	**25·77**	**107·16**
Total	1920	572	£ 17·09	£ 25·25	£ 11·68	£ 17·35	£ 17·27	£ 16·64	£ 105·28
	1921	581	17·64	25·22	14·75	16·87	17·46	22·23	114·17
	1922	587	18·48	28·03	15·79	14·53	17·20	21·15	115·18
	1923	624	18·96	30·28	16·67	13·69	16·93	23·17	119··
	1924	**662**	**19·31**	**33·91**	**17·49**	**10·28**	**17·33**	**19·53**	**117**

EXPENDITURE PER AVAILABLE BED.



Illustrating Table 29.

ANALYSIS OF THE PRINCIPAL ITEMS VOLUNTARY HOSPITALS

Table 29 gives an analysis of the principal items, amounting to about 86 per cent. of the Total Ordinary Expenditure. The higher costs of most commodities are specially referred to in many of the reports and are reflected in the figures of each group. The experience of the Hospital in this respect is common knowledge to every family in the country, but with this difference, that while the healthy can to some extent adjust their standard of living to the increased costs, the hospitals are obliged to maintain their standard, irrespective of fluctuations in prices.

TABLE 29.

ANALYSIS OF THE PRINCIPAL ITEMS OF

Hospitals.	Year.	No. of Hospitals giving details.	No. of available beds.	Provisions.		Surgery and Dispensary.	
				Total.	Per *available* bed.	Total.	Per *available* bed.
Group A	1921	108	20,525	£ 699,825	£ 34·09	£ 369,462	£ 18·00
	1922	109	20,960	587,357	28·02	331,407	15·81
	1923	115	22,071	603,529	27·34	371,651	16·84
	1924	**114**	**21,624**	**605,628**	**28·01**	**395,394**	**18·28**
Group B	1921	159	8,165	265,655	32·54	120,712	14·78
	1922	163	8,403	225,202	26·80	114,744	13·65
	1923	176	8,835	225,633	25·54	120,566	13·65
	1924	**183**	**9,260**	**242,271**	**26·16**	**130,700**	**14·12**
Group C	1921	280	4,105	125,430	30·56	45,694	11·13
	1922	283	4,223	107,826	25·53	41,406	9·81
	1923	282	4,271	108,122	25·32	45,978	10·77
	1924	**297**	**4,530**	**113,394**	**25·03**	**48,124**	**10·62**
Total	1921	547	32,795	£ 1,090,910	£ 33·26	£ 535,868	£ 16·34
	1922	555	33,586	920,385	27·40	487,557	14·52
	1923	573	35,177	937,284	26·64	538,195	15·30
	1924	**594**	**35,414**	**961,293**	**27·14**	**574,218**	**16·21**

OF ORDINARY EXPENDITURE OF THE IN ENGLAND AND WALES.

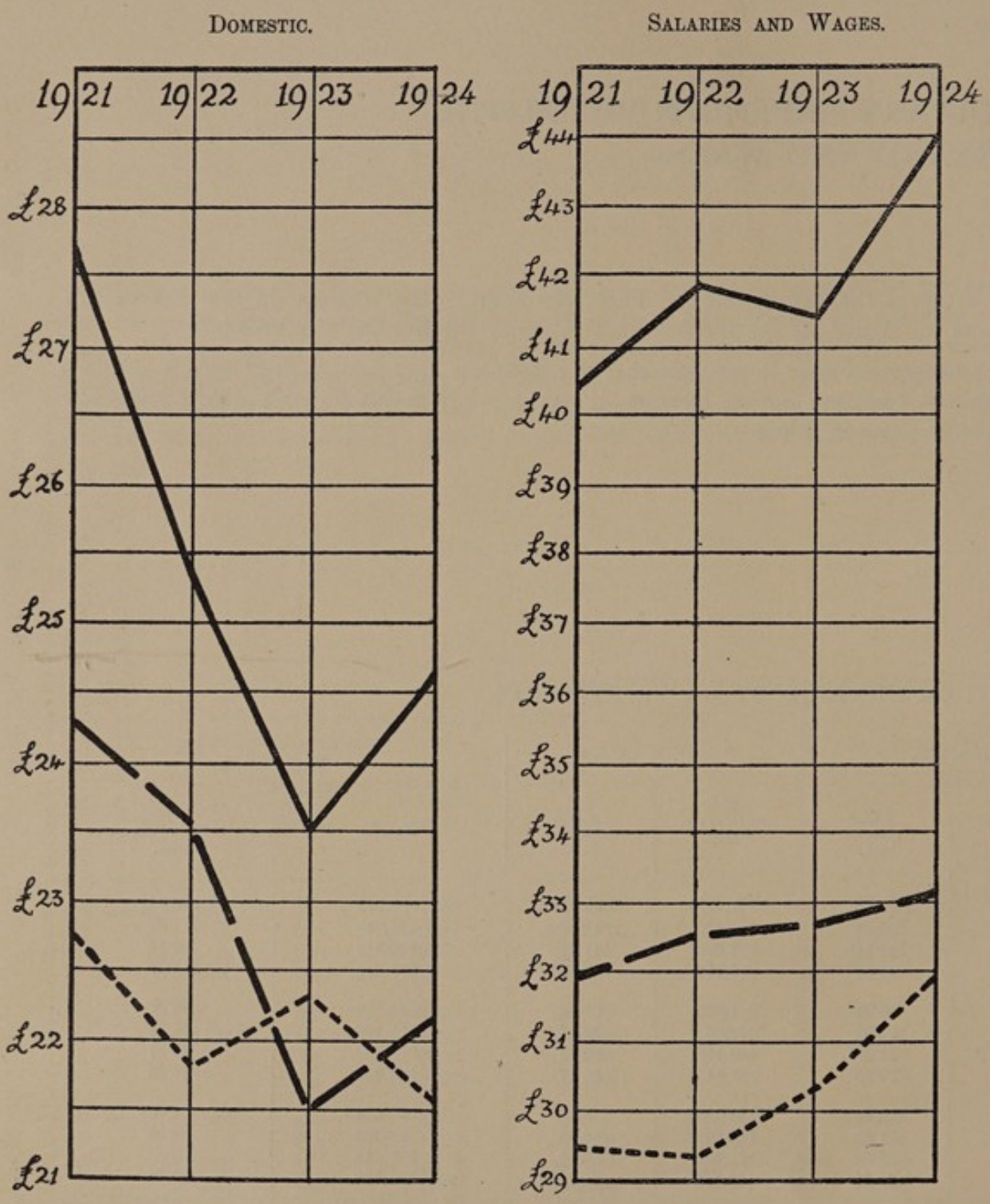
Table 31 gives the expenditure on Fuel and Light. The increase in the cost of this item accounts for almost all the increase in cost under the heading " Domestic."

It is probably not unfair to conclude that the Hospitals have now attained such a standard of efficiency and economy that an increase in cost per bed means probably either some new developments or a rise in prices.

ORDINARY EXPENDITURE BY GROUP AVERAGES.

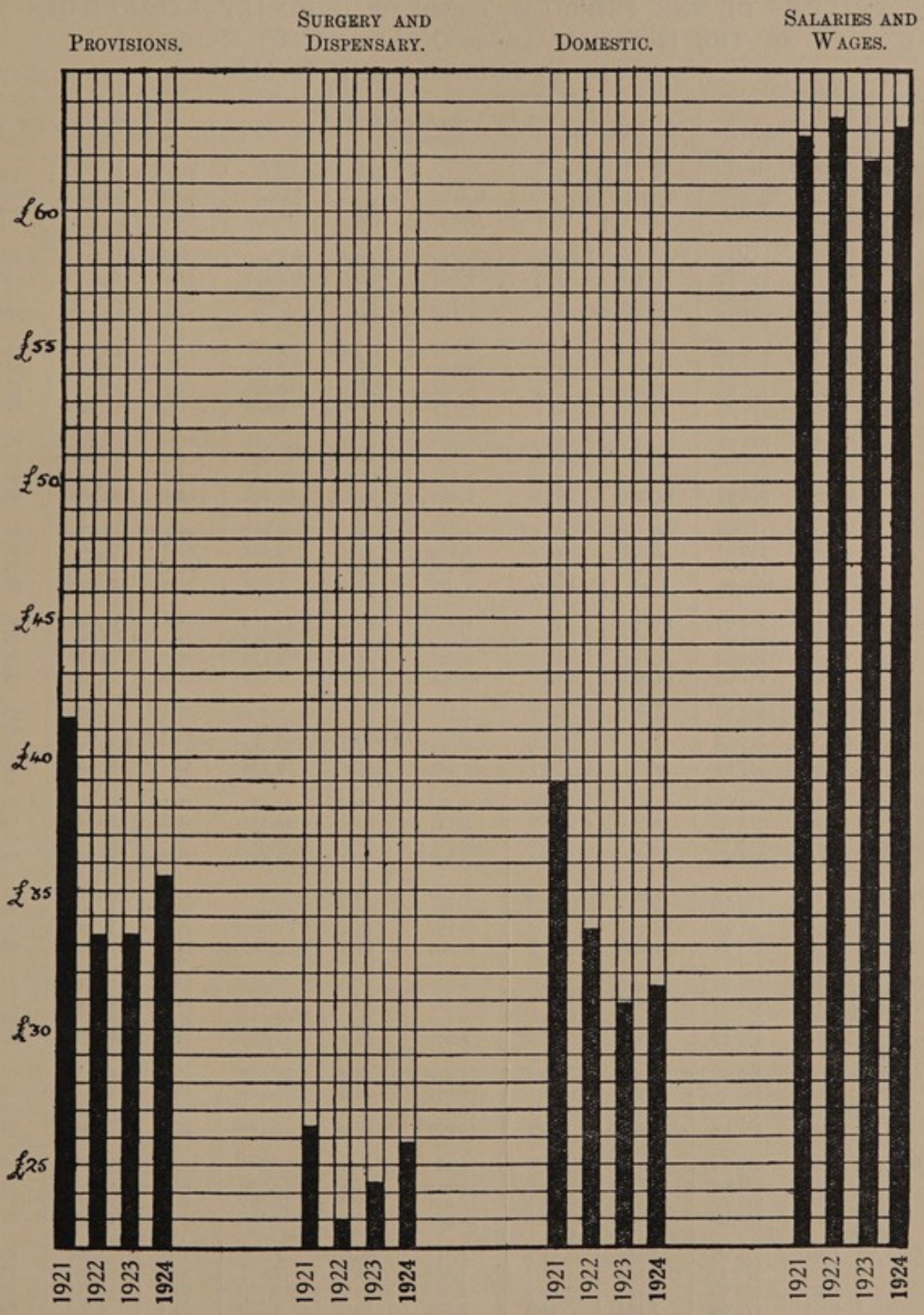
Domestic.		Salaries and Wages.		Total Expenditure under the four headings.	
Total.	Per *available* bed.	Total.	Per *available* bed.	Total.	Per *available* bed.
£ 569,505	£ 27·75	£ 831,410	£ 40·51	£ 2,470,202	£ 120·35
532,131	25·39	877,450	41·87	2,328,345	111·09
519,668	23·54	914,095	41·42	2,408,943	109·14
533,242	**24·66**	**952,126**	**44·03**	**2,486,390**	**114·98**
198,476	24·31	261,075	31·97	845,918	103·60
198,191	23·59	273,653	32·57	811,790	96·61
190,405	21·55	289,179	32·73	825,783	93·47
205,571	**22·20**	**307,147**	**33·17**	**885,689**	**95·65**
93,601	22·80	121,134	29·51	385,859	94·00
92,281	21·85	123,949	29·35	365,462	86·54
95,435	22·34	129,430	30·30	378,965	88·73
97,967	**21·63**	**144,818**	**31·97**	**404,303**	**89·25**
£ 861,582	£ 26·27	£ 1,213,619	£ 37·01	£ 3,701,979	£ 112·88
822,603	24·49	1,275,052	37·96	3,505,597	104·37
805,508	22·90	1,332,704	37·89	3,613,691	102·73
836,780	**23·63**	**1,404,091**	**39·65**	**3,776,382**	**106·63**

EXPENDITURE PER AVAILABLE BED.



Illustrating Table 29.

EXPENDITURE PER OCCUPIED BED IN HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN ENGLAND AND WALES.



Illustrating Table 30.

TABLE 30.

ANALYSIS OF THE PRINCIPAL ITEMS OF ORDINARY EXPENDITURE OF THE 14 HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN ENGLAND AND WALES.

Hospital.	Year.	Average No. of beds occupied daily.	Provisions.		Surgery and Dispensary.		Domestic.		Salaries and Wages.	
			Total.	Per *occupied* bed.	Total.	Per *occupied* bed.	Total.	Per *occupied* bed.	Total.	Per *occupied* bed.
A ...	1921	260·00	£ 10,191	£ 39·2	£ 7,847	£ 30·2	£ 9,700	£ 37·3	£ 14,684	£ 56·5
	1922	273·59	7,853	28·7	7,266	26·6	8,086	29·5	15,082	55·1
	1923	280·56	7,822	27·9	8,272	29·5	7,396	26·4	14,339	51·1
	1924	**277·12**	**8,469**	**30·6**	**7,715**	**27·8**	**6,799**	**24·5**	**13,929**	**50·3**
B ...	1921	172·18	8,581	49·8	4,746	27·6	8,121	47·2	10,025	58·2
	1922	181·85	6,885	37·8	4,163	22·9	7,533	41·4	10,381	57·1
	1923	189·50	7,100	37·5	4,695	24·8	6,462	34·1	10,827	57·1
	1924	**199·88**	**7,515**	**37·6**	**5,577**	**27·9**	**6,275**	**31·4**	**11,681**	**58·4**
C ...	1921	317·00	13,429	42·4	7,462	23·5	18,016	56·8	19,760	62·3
	1922	297·00	11,056	37·2	5,626	18·9	11,945	40·2	19,263	64·9
	1923	314·00	11,697	37·3	8,884	28·3	12,710	40·5	19,480	62·0
	1924	**318·00**	**12,896**	**40·6**	**9,293**	**29·2**	**12,834**	**40·4**	**20,789**	**65·4**
D ...	1921	178·80	7,429	41·5	3,527	19·8	6,992	39·1	11,712	65·5
	1922	180·80	6,106	33·8	4,924	27·2	5,693	31·5	12,197	67·5
	1923	181·70	6,306	34·7	5,216	28·7	5,742	31·6	12,332	67·9
	1924	**185·80**	**6,443**	**34·7**	**5,995**	**32·3**	**5,534**	**29·8**	**12,673**	**68·2**
E ...	1921	335·00	13,329	39·8	9,453	28·2	11,313	33·8	11,769	35·1
	1922	341·00	11,544	33·8	8,572	25·1	8,312	24·4	12,165	35·7
	1923	351·00	13,157	37·5	9,936	28·3	8,955	25·5	12,733	36·3
	1924	**341·00**	**14,622**	**42·9**	**10,054**	**29·5**	**9,310**	**27·3**	**13,888**	**40·7**
F ...	1921	204·00	9,407	46·1	7,174	35·2	7,754	38·0	8,833	43·3
	1922	210·00	6,560	31·2	4,953	23·6	6,012	28·6	8,801	41·9
	1923	234·00	7,839	33·5	7,111	30·4	7,953	34·0	9,714	41·5
	1924	**274·00**	**9,791**	**35·7**	**8,045**	**29·4**	**9,806**	**35·8**	**12,000**	**43·8**
G ...	1921	269·00	10,275	38·2	5,798	21·5	11,133	41·4	16,354	60·8
	1922	275·60	8,510	30·9	5,728	20·8	10,498	38·1	17,287	62·7
	1923	287·70	9,383	32·6	6,247	21·7	10,974	38·1	18,020	62·6
	1924	**300·00**	**12,079**	**40·3**	**8,099**	**27·0**	**12,489**	**41·6**	**19,062**	**63·5**
H ...	1921	232·29	8,639	37·2	5,869	25·3	7,098	30·6	14,969	64·4
	1922	239·15	6,597	27·6	5,268	22·0	5,457	22·8	15,223	63·7
	1923	241·88	6,654	27·5	5,167	21·4	5,706	23·6	14,643	60·5
	1924	**245·25**	**7,709**	**31·4**	**6,940**	**28·3**	**5,609**	**22·9**	**15,210**	**62·0**
I ...	1921	529·00	23,407	44·2	8,262	15·6	18,519	35·0	37,610	71·1
	1922	524·46	19,612	37·4	7,379	14·0	20,077	38·3	38,121	72·7
	1923	541·00	20,415	37·7	7,049	13·0	15,782	29·2	39,571	73·1
	1924	**539·00**	**20,965**	**38·9**	**7,556**	**14·4**	**17,235**	**32·0**	**40,536**	**75·2**
J ...	1921	429·00	17,049	39·7	16,870	39·3	19,579	45·6	26,992	62·9
	1922	445·00	14,000	31·5	15,035	33·8	18,258	41·0	28,841	64·8
	1923	461·00	13,672	29·7	16,252	35·3	15,995	34·7	30,008	65·1
	1924	**467·00**	**13,619**	**29·2**	**14,960**	**32·0**	**15,198**	**32·5**	**29,945**	**64·1**
K ...	1921	512·60	18,967	37·0	13,864	27·1	16,783	32·7	47,503	92·7
	1922	525·40	15,567	29·6	11,278	21·5	14,063	26·8	44,631	84·9
	1923	537·40	14,356	26·7	10,629	19·8	13,501	25·1	43,748	81·4
	1924	**539·00**	**14,730**	**27·3**	**10,661**	**19·8**	**13,123**	**24·3**	**43,971**	**81·6**
L ...	1921	174·00	7,180	41·3	4,547	26·1	7,210	41·4	10,557	60·7
	1922	176·00	7,334	41·7	4,546	25·8	7,067	40·2	14,257	81·0
	1923	169·00	6,923	40·9	4,177	24·7	5,853	34·6	13,710	81·1
	1924	**172·00**	**7,104**	**41·3**	**5,054**	**29·4**	**5,920**	**34·4**	**4 652**	**85.2**

TABLE 30.—*continued.*

Hospital.	Year.	Average No. of beds occupied daily.	Provisions.		Surgery and Dispensary.		Domestic.		Salaries and Wages.	
			Total.	Per *occupied* bed.	Total.	Per *occupied* bed.	Total.	Per *occupied* bed.	Total.	Per *occupied* bed.
M ...	1921	163·00	8,259	50·6	4,091	25·1	4,789	29·4	6,501	39·9
	1922	168·00	6,355	37·8	3,627	21·6	4,414	26·3	7,027	41·8
	1923	179·00	5,924	33·1	3,301	18·4	4,296	24·0	6,601	36·9
	1924	**174·00**	**5,682**	**32·1**	**3,886**	**22·3**	**4,346**	**25·0**	**6,775**	**38·9**
N* ...	1923	318·60	11,653	36·6	7,442	23·4	11,258	35·3	19,666	61·7
	1924	323·80	**13,058**	**40·3**	**8,579**	**26·5**	**12,825**	**39·6**	**19,902**	**61·5**
Total	1921	3,775·87	£ 156,142	£ 41·4	£ 99,510	£ 26·4	£ 147,007	£ 38·9	£ 237,269	£ 62·8
	1922	3,837·85	127,979	33·3	88,365	23·0	127,415	33·5	243,276	63·4
	1923	4,286·34	142,901	33·3	104,378	24·4	132,583	30·9	265,392	61·9
	1924	**4,355·85**	**154,682**	**35·5**	**112,414**	**25·8**	**137,303**	**31·5**	**275,013**	**63·1**

* Recognised as a Medical School during 1923.

TABLE 31.

EXPENDITURE ON FUEL AND LIGHT.

Hospitals.	Year.	No. of Hospitals giving details.	No. of available beds.	Coal and Coke.		Gas and Electricity.		Total Fuel and Light.	
				Total.	Per available bed.	Total.	Per available bed.	Total.	Per available bed.
Group A ...	1921	90	17,727	£ 206,996	£ 11·68	£ 93,022	£ 5·24	£ 300,018	£ 16·92
	1922	105	20,459	190,483	9·31	104,336	5·10	294,819	14·41
	1923	110	21,445	176,867	8·25	95,347	4·44	272,214	12·69
	1924	**112**	**21,424**	**194,380**	**9·07**	**92,354**	**4·31**	**286,734**	**13·38**
Group B ...	1921	116	6,346	47,187	7·43	33,494	5·28	80,681	12·71
	1922	120	6,472	43,309	6·69	34,190	5·28	77,499	11·97
	1923	136	7,138	42,843	6·00	33,143	4·64	75,986	10·64
	1924	**144**	**7,591**	**48,084**	**6·33**	**33,473**	**4·41**	**81,557**	**10·74**
Group C ...	1921	173	2,495	16,639	6·67	11,840	4·74	28,479	11·41
	1922	167	2,452	14,989	6·11	11,061	4·51	26,050	10·62
	1923	184	2,806	15,377	5·48	12,072	4·30	27,449	9·78
	1924	**181**	**2,781**	**17,044**	**6·13**	**12,450**	**4·48**	**29,494**	**10·61**
Total ...	1921	379 = 65% (*a*)	26,568 = 79·65% (*b*)	£ 270,822	£ 10·19	£ 138,356	£ 5·21	£ 409,178	£ 15·40
	1922	392 = 67% (*a*)	29,383 = 86·50% (*b*)	248,781	8·47	149,587	5·09	398,368	13·56
	1923	430 = 69% (*a*)	31,389 = 87·00% (*b*)	235,087	7·49	140,562	4·48	375,649	11·97
	1924	**437 = 66% (*a*)**	**31,796 = 86·33% (*b*)**	**259,508**	**8·16**	**138,277**	**4·35**	**397,785**	**12·51**

(*a*) Percentage of Hospitals reviewed.

(*b*) Percentage of total available beds in Hospitals reviewed.

SECTION 5.

VOLUME OF WORK DONE IN THE VOLUNTARY HOSPITALS IN SCOTLAND.

That the number of beds available for the treatment of patients in Scotland is somewhat in excess of that which the Hospital Reports show as their establishments is clear from Table 35.

In this Table the average number of beds occupied daily in one of the Hospitals returning its available beds as 664 was 726.60, and in another returning its available beds as 260 the average number of beds occupied daily was 294. Similar excesses of occupation over establishment have occurred during the preceding four years.

It is to be noted that Out-patient work in Scotland as in England is increasing. This increase is most marked in the A Group, between 30,000 and 40,000 more Out-patients having been treated in 1924 than in 1923.

Table 33 deals with only a small number of Hospitals. So far as it goes it points in the same direction as the corresponding Table for the English Group, viz., that Special Hospitals deal with relatively a very much larger number of Out-patients than the General Hospitals.

TABLE 32.

NUMBER OF IN-PATIENTS AND OUT-PATIENTS TREATED AND PERCENTAGE OF AVAILABLE BEDS OCCUPIED.

Hospitals.	Year.	No. of Hospitals giving details.	No. of available beds.	Percentage of available beds occupied daily.	No. of New In-patients.	No. of New Out-patients.
Group A ...	1920	18	4,918	92·39%	71,939	240,701
	1921	17	5,163	87·36%	71,172	227,048
	1922	18	5,316	87·28%	78,143	250,327
	1923	19	5,435	90·81%	82,822	257,700
	1924	**19**	**5,495**	**91·80%**	**88,140**	**290,730**
Group B ...	1920	20	1,101	80·86%	14,019	36,671
	1921	20	1,142	77·59%	12,716	35,827
	1922	19	1,122	83·57%	14,074	35,711
	1923	20	1,149	86·53%	14,728	36,894
	1924	**20**	**1,210**	**82·47%**	**15,067**	**38,363**
Group C ...	1920	37	539	77·16%	5,807	32,060
	1921	36	550	72·75%	6,516	22,632
	1922	35	537	61·16%	6,692	25,534
	1923	46	728	63·32%	7,544	30,590
	1924	**53**	**844**	**59·33%**	**8,063**	**30,622**
Total ...	1920	75=96% (*a*)	6,558=99% (*b*)		91,765	309,432
	1921	73=97% (*a*)	6,855=99% (*b*)		90,404	285,507
	1922	72=91% (*a*)	6,975=99% (*b*)		98,909	311,572
	1923	85=99% (*a*)	7,312=99% (*b*)		105,094	325,184
	1924	**92=99% (*a*)**	**7,549=99% (*b*)**		**111,270**	**359,715**

(*a*) Percentage of Hospitals reviewed.

(*b*) Percentage of total available beds in Hospitals reviewed.

TABLE 33.

NUMBER OF PATIENTS TREATED IN GENERAL AND SPECIAL HOSPITALS DURING 1923 SHOWN SEPARATELY.

Hospitals.	No. of Hospitals giving details.	No. of available beds.	No. of New In-patients.	No. of New Out-patients.
General Hospitals—				
Group A	15	4,796	73,373	215,825
Group B	12	679	7,966	12,283
Group C	44	688	5,893	4,550
Total of General Hospitals	71	6,163	87,232	232,658
Special Hospitals—				
Group A	4	699	14,767	74,905
Group B	8	531	7,101	26,080
Group C	9	156	2,170	26,072
Total of Special Hospitals	21	1,386	24,038	127,057

TABLE 34.

NUMBER OF SURGICAL OPERATIONS UNDER GENERAL ANÆSTHETIC.

Hospitals.	Year.	No. of Hospitals giving details.	No. of available beds.	No. of operations.
Group A	1921	17	5,163	42,769
	1922	18	5,316	53,523
	1923	19	5,435	59,064
	1924	**18**	**5,391**	**61,082**
Group B	1921	14	819	8,566
	1922	13	779	9,094
	1923	16	889	9,717
	1924	**17**	**1,043**	**10,489**
Group C	1921	26	390	5,815
	1922	28	399	5,910
	1923	38	591	7,549
	1924	**44**	**693**	**8,610**
Total	1921	57=76% (*a*)	6,372=92·52% (*b*)	57,150
	1922	59=75% (*a*)	6,494=91·79% (*b*)	68,527
	1923	73=85% (*a*)	6,915=94·39% (*b*)	76,330
	1924	**79=85%** (*a*)	**7,127=93·99%** (*b*)	**80,181**

(*a*) Percentage of Hospitals reviewed.

(*b*) Percentage of total available beds in Hospitals reviewed.

TABLE 35.

SURVEY OF THE WORK DONE IN THE SIX HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN SCOTLAND.

1	2	3	4	5	6	7	8	9	10
Hospital.	Year.	No. of available beds.	Average No. of beds occupied daily.	Percentage of available beds occupied.	No. of New In-patients	No. of In-patients per occupied bed.	Average length of stay per In-patient (days).	No. of New Out-patients.	No. of Surgical Operations.
A	1920	270	253·00	93·70	3,369	13·31	28·00	14,650	3,290
	1921	270	249·00	92·22	3,554	14·31	25·00	15,246	3,403
	1922	270	269·00	99·63	3,687	13·71	25·00	14,401	3,139
	1923	304	285·00	93·75	3,896	13·67	25·00	15,577	3,586
	1924	**304**	**297·00**	**97·70**	**4,219**	**14·21**	**24·00**	**18,111**	**4,339**
B	1920	400	342·00	85·50	5,441	15·91	23·90	17,952	3,767
	1921	414	326·00	78·74	4,610	14·14	23·20	17,737	3,795
	1922	414	332·33	80·27	5,588	16·81	21·68	14,804	—
	1923	422	333·36	79·00	5,816	17·45	20·71	15,365	4,979
	1924	**427**	**355·26**	**83·20**	**6,479**	**18·24**	**19·77**	**15,773**	**5,179**
C	1920	963	875·00	90·86	12,521	14·31	24·05	48,117	—
	1921	963	869·00	90·24	12,814	14·74	22·20	41,859	6,765
	1922	963	876·00	90·97	13,372	15·26	22·10	42,342	6,582
	1923	963	897·00	93·15	14,231	15·84	21·30	46,693	6,840
	1924	**963**	**903·00**	**93·77**	**14,883**	**16·48**	**20·68**	**48,349**	**7,781**
D	1920	665	680·80	102·37	10,474	15·38	22·40	40,522	8,733
	1921	665	680·20	102·29	10,155	14·93	23·00	41,857	8,843
	1922	665	657·90	98·93	10,809	16·43	21·10	44,689	8,613
	1923	665	722·90	108·72	12,106	16·75	20·70	48,693	10,062
	1924	**664**	**726·60**	**109·43**	**13,297**	**18·30**	**19·00**	**51,954**	**9,522**
E	1920	600	587·00	97·83	8,938	15·23	22·37	26,871	—
	1921	600	557.00	92·83	8,988	16·14	21·25	26,129	5,029
	1922	600	555·00	92·50	10,766	19·40	20·81	35,167	6,126
	1923	600	554·00	92·33	9,444	17·05	20·29	32,450	5,600
	1924	**600**	**548·00**	**91·33**	**9,871**	**18·01**	**19·23**	**35,265**	**5,551**
F	1920	260	271·00	104·23	3,971	14·65	25·20	10,423	2,153
	1921	260	283·00	108·85	4,082	14·42	25·00	12,132	2,150
	1922	260	286·00	110·00	3,950	13·81	25·90	9,881	2,025
	1923	260	288·00	110·77	4,223	14·66	24·40	11,843	1,987
	1924	**260**	**294·00**	**113·08**	**4,167**	**14·17**	**25·00**	**12,937**	**2,245**
Total ...	1920	3,158	3,008·80	95·28	44,714	14·86		158,535	
	1921	3,172	2,964·20	93·45	44,203	14·91		154,960	
	1922	3,172	2,976·23	93·83	48,172	16·19		161,284	
	1923	3,214	3,080·26	95·84	49,716	16·14		170,621	
	1924	**3,218**	**3,123·86**	**97·07**	**52,916**	**16·94**		**182,389**	

* Year ended 15th May.

SECTION 6.

FINANCIAL POSITION OF THE VOLUNTARY HOSPITALS IN SCOTLAND.

(A) TOTAL RECEIPTS AND TOTAL EXPENDITURE.

Table 36 is typical of the Voluntary System. An examination of the records of almost any Hospital will reveal the occurrence, at often surprisingly regular intervals, of windfall years. The year 1924 appears to have been such a one in Scotland.

Whereas in the English group of Hospitals the year 1924 ended with a surplus that was little more than half that of the preceding year, in Scotland the process was reversed and the surplus of 1923 was almost doubled. This prosperity was not, it is true, shared universally throughout Scotland, as the percentage of Hospitals having an excess of Total Receipts over Total Expenditure fell from 88 to 76, but the total deficit of those which failed to make both ends meet did not exceed £24,398, or approximately one-thirtieth part of the surplus of those which did.

(B) ORDINARY INCOME AND ORDINARY EXPENDITURE.

We have pointed out from time to time the conspicuous part which " Free Legacies " plays in the Finances of the Scottish Hospitals. In the year 1924 this fact is even more conspicuous than usual (see page 11). For the purposes of comparison with the English Hospitals an analysis of so-called " Ordinary Income " in the Scottish Hospitals is of no value. We therefore confine our comments to the Ordinary Expenditure. The trend of Expenditure can be most readily seen either in the graphs or from the following figures taken from Tables 15 and 43 :—

RISE (+) OR FALL (−) IN ORDINARY EXPENDITURE, 1924, PER AVAILABLE BED.

	Scotland.		*England.*
A Group	+£4	...	+£5
B Group	+ 1	...	No change.
C Group	− 3	...	+ 1
	+£3		+£2

The Scottish Hospitals as a whole cost in 1924 approximately £8 per available bed less to maintain than the English.

It is worthy of note that the average cost per occupied bed of the Scottish group of Medical School Hospitals is £143 per annum, whereas the average cost per occupied bed of the English group of Medical School Hospitals is £182 per annum, and that in only one of the Scottish group does the cost approach the average cost of the English group. The English Medical School Hospitals, however, treat approximately twice as many Out-patients per occupied bed as the Scottish, and this fact must have some considerable influence in determining the difference in cost.

TABLE 36.

TOTAL RECEIPTS AND TOTAL EXPENDITURE.

Hospitals.	Year.	No. of Hospitals.	Total Receipts.	Total Expenditure.	Surplus.
Group A	1920	18	£ 976,198	£ 750,033	£ 226,165
	1921	17	884,613	769,158	115,455
	1922	18	942,144	677,291	264,853
	1923	19	951,586	720,890	230,696
	1924	**19**	**1,243,213**	**762,601**	**480,612**
Group B	1920	21	182,507	131,714	50,793
	1921	20	172,835	126,722	46,113
	1922	20	197,191	126,347	70,844
	1923	20	220,029	132,176	87,853
	1924	**21**	**342,496**	**167,413**	**175,083**
Group C	1920	39	92,386	64,273	28,113
	1921	38	84,371	66,350	18,021
	1922	41	80,735	65,205	15,530
	1923	47	132,672	74,327	58,345
	1924	**53**	**128,214**	**87,767**	**40,447**
Total	1920	78	£ 1,251,091	£ 946,020	£ 305,071
	1921	75	1,141,819	962,230	179,589
	1922	79	1,220,070	868,843	351,227
	1923	86	1,304,287	927,393	376,894
	1924	**93**	**1,713,923**	**1,017,781**	**696,142**

TABLE 37.

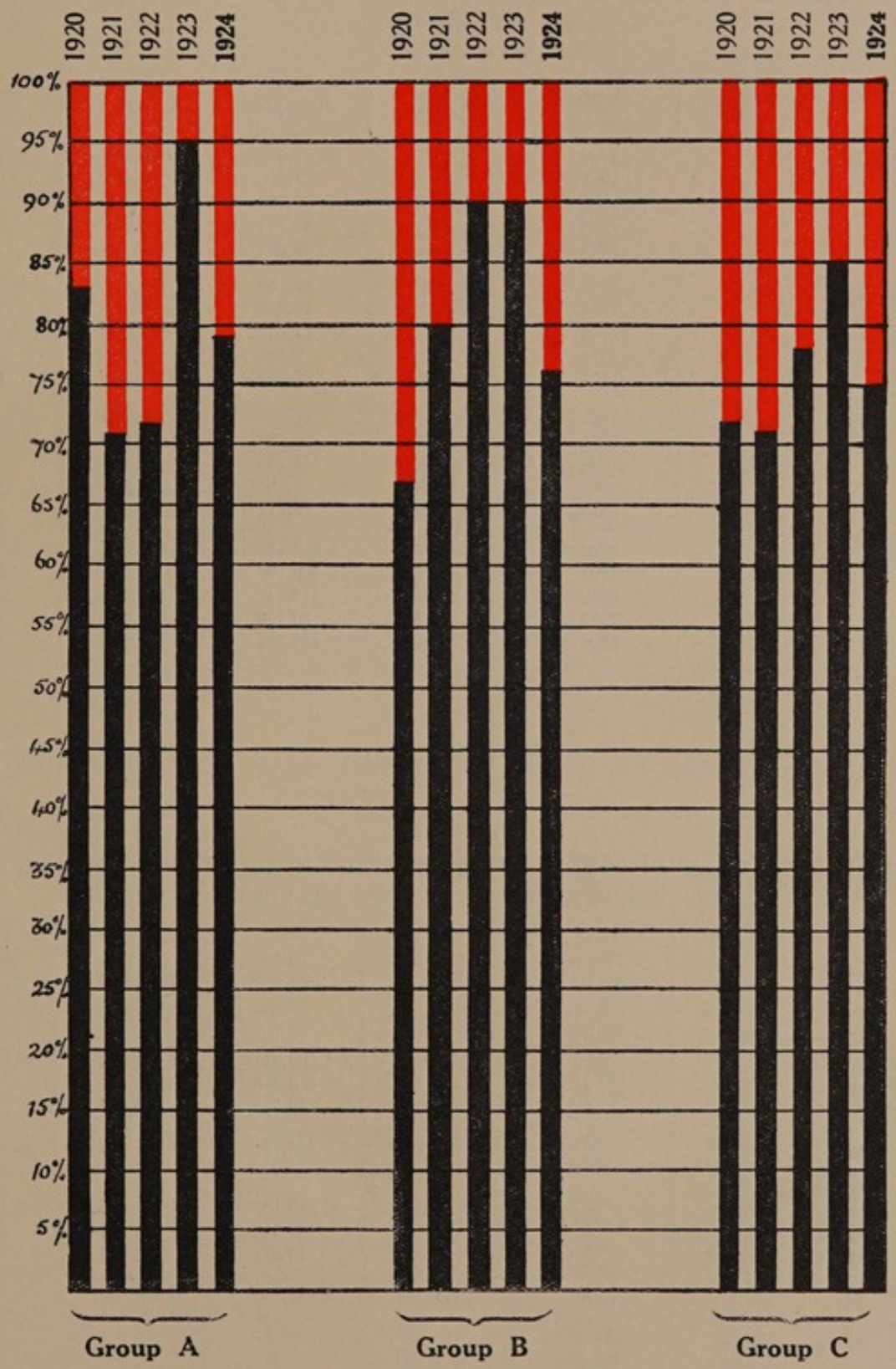
HOSPITALS HAVING AN **EXCESS OF TOTAL RECEIPTS** OVER TOTAL EXPENDITURE.

Hospitals.	Year.	No. of Hospitals.	Total Receipts.	Total Expenditure.	Surplus.
Group A	1920	15 (83%)	£ 914,358	£ 674,914	£ 239,444
	1921	12 (71%)	752,920	606,677	146,243
	1922	**13 (72%)**	855,479	581,049	274,430
	1923	18 (95%)	938,274	700,142	238,132
	1924	**15 (79%)**	**1,156,358**	**666,829**	**489,529**
Group B	1920	14 (67%)	147,307	92,297	55,010
	1921	16 (80%)	155,835	106,903	48,932
	1922	18 (90%)	185,903	114,539	71,364
	1923	18 (90%)	212,436	123,775	88,661
	1924	**16 (76%)**	**307,989**	**120,693**	**187,296**
Group C	1920	28 (72%)	77,001	44,151	32,850
	1921	27 (71%)	63,568	39,010	24,558
	1922	32 (78%)	66,545	45,850	20,695
	1923	40 (85%)	122,839	62,372	60,467
	1924	**40 (75%)**	**107,943**	**64,228**	**43,715**
Total	1920	57 (73%)	£ 1,138,666	£ 811,362	327,304
	1921	55 (73%)	972,323	752,590	219,733
	1922	63 (80%)	1,107,927	741,438	366,489
	1923	76 (88%)	1,273,549	886,289	387,260
	1924	**71 (76%)**	**1,572,290**	**851,750**	**720,540**

PERCENTAGE OF HOSPITALS HAVING AN EXCESS OF :—

TOTAL RECEIPTS ... ... Shown in Black.

TOTAL EXPENDITURE ... Shown in Red.



Illustrating Tables 37 and 38.

TABLE 38.

HOSPITALS HAVING AN **EXCESS OF TOTAL EXPENDITURE** OVER TOTAL RECEIPTS.

Hospitals.	Year.	No. of Hospitals.	Total Receipts.	Total Expenditure.	Deficit.
Group A	1920	3 (17%)	£ 61,840	£ 75,119	£ 13,279
	1921	5 (29%)	131,693	162,481	30,788
	1922	5 (28%)	86,665	96,242	9,577
	1923	1 (5%)	13,312	20,748	7,436
	1924	**4 (21%)**	**86,855**	**95,772**	**8,917**
Group B	1920	7 (33%)	35,200	39,417	4,217
	1921	4 (20%)	17,000	19,819	2,819
	1922	2 (10%)	11,288	11,808	520
	1923	2 (10%)	7,593	8,401	808
	1924	**5 (24%)**	**34,507**	**46,720**	**12,213**
Group C	1920	11 (28%)	15,385	20,122	4,737
	1921	11 (29%)	20,803	27,340	6,537
	1922	9 (22%)	14,190	19,355	5,165
	1923	7 (15%)	9,833	11,955	2,122
	1924	**13 (25%)**	**20,271**	**23,539**	**3,268**
Total	1920	21 (27%)	£ 112,425	£ 134,658	£ 22,233
	1921	20 (27%)	169,496	209,640	40 144
	1922	16 (20%)	112,143	127,405	15,262
	1923	10 (12%)	30,738	41,104	10,366
	1924	**22 (24%)**	**141,633**	**166,031**	**24,398**

TABLE 39.

TOTAL RECEIPTS AND TOTAL EXPENDITURE OF GENERAL AND SPECIAL HOSPITALS SHOWN SEPARATELY.

Hospitals.	No. of Hospitals.	Available Beds.	Total Receipts.	Total Expenditure.	Surplus.
General Hospitals—					
Group A	15	4,796	£ 1,003,015	£ 654,061	£ 348,954
Group B	13	713	103,916	66.175	37,741
Group C	44	688	79,543	66,006	13,537
Total	72	6,197	£ 1,186,474	£ 786,242	£ 400,232
Special Hospitals—					
Group A	4	699	£ 240,198	£ 108,540	£ 131,658
Group B	8	531	238,580	101,238	137,342
Group C	9	156	48 671	21,761	26,910
Total	21	1,386	£ 527,449	£ 231,539	£ 295,910

TABLE 40.

ORDINARY INCOME AND EXPENDITURE.

Hospitals.	Year.	No. of Hospitals.	Total Ordinary Income.	Total Ordinary Expenditure.	Deficit.	Surplus.
Group A...	1920	18	£ 612,884	£ 689,094	£ 76,210	—
	1921	17	605,120	672,927	67,807	—
	1922	18	563,302	631,437	68,135	—
	1923	19	561,243	644,420	83,177	—
	1924	**19**	**595,948**	**674,833**	**78,885**	—
Group B...	1920	21	124,122	125,864	1,742	—
	1921	20	117,946	121,018	3,072	—
	1922	20	123,507	114,259	—	£ 9,248
	1923	20	127,451	111,096	—	16,355
	1924	**21**	**137,156**	**121,931**	—	**15,225**
Group C...	1920	39	56,982	57,188	206	—
	1921	38	62,804	61,134	—	1,670
	1922	41	63,657	58,981	—	4,676
	1923	47	76,853	66,049	—	10,804
	1924	**53**	**81,788**	**72,610**	—	**9,178**
Total ...	1920	78	£ 793,988	£ 872,146	£ 78,158	—
	1921	75	785,870	855,079	69,209	—
	1922	79	750,466	804,677	54,211	—
	1923	86	765,547	821,565	56,018	—
	1924	**93**	**814,892**	**869,374**	**54,482**	—

TABLE 41.

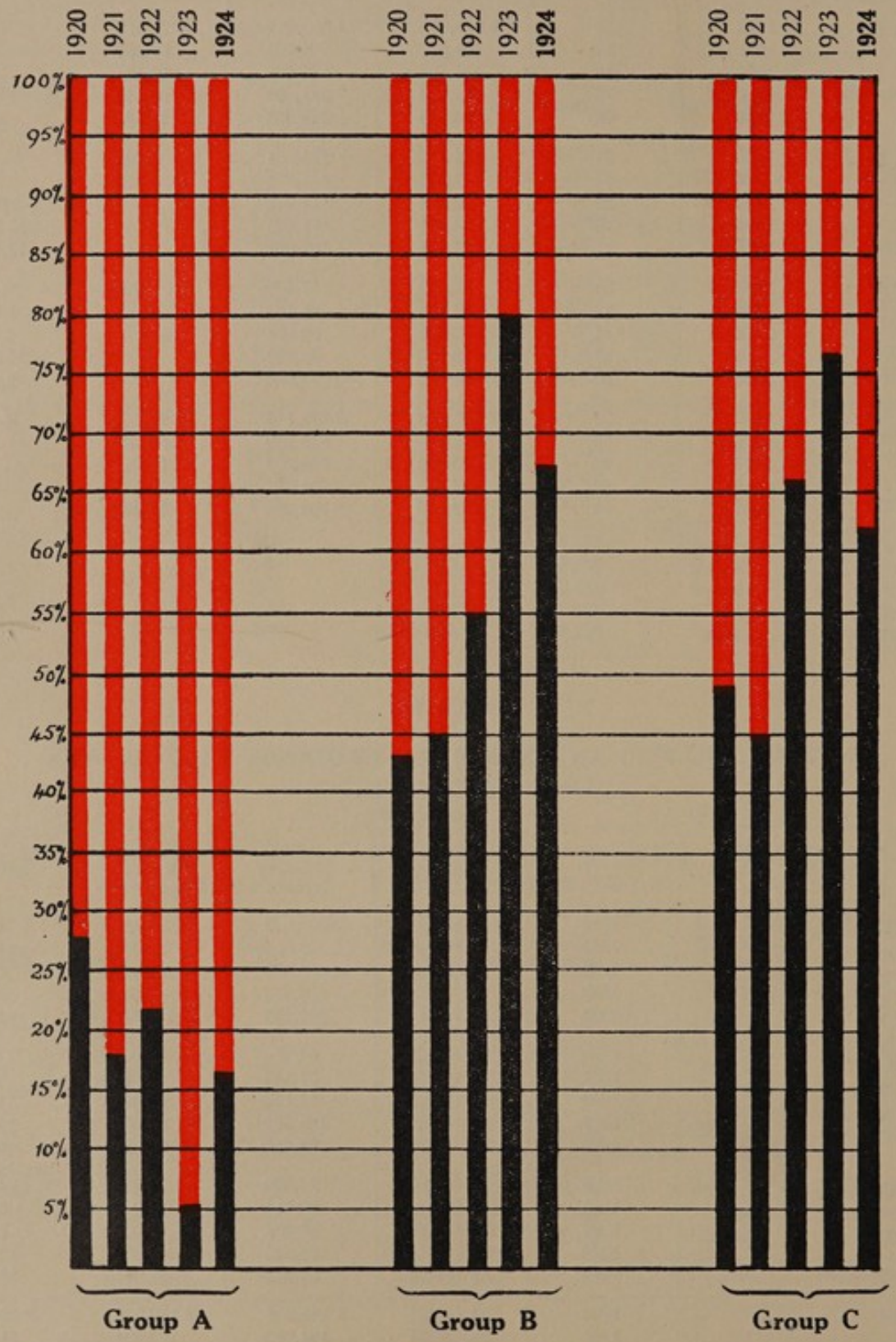
HOSPITALS HAVING AN **EXCESS OF ORDINARY INCOME** OVER ORDINARY EXPENDITURE.

Hospitals.	Year.	No. of Hospitals.	Total Ordinary Income.	Total Ordinary Expenditure.	Surplus.
Group A	1920	5 (28%)	£ 99,682	£ 78,118	£ 21,564
	1921	3 (18%)	103,883	88,551	15,332
	1922	4 (22%)	55,661	50,538	5,123
	1923	1 (5%)	5,775	5,632	143
	1924	**3 (16%)**	**156,235**	**154,628**	**1,607**
Group B	1920	9 (43%)	64,910	51,051	13,463
	1921	9 (45%)	57,142	49,051	8,091
	1922	11 (55%)	73,130	58,821	14,309
	1923	16 (80%)	106,739	87,863	18,876
	1924	**14 (67%)**	**99,940**	**81,579**	**18,361**
Group C	1920	19 (49%)	27,329	22,515	4,814
	1921	17 (45%)	33,214	24,952	8,262
	1922	27 (66%)	40,886	33,058	7,828
	1923	36 (77%)	63,129	49,802	13,327
	1924	**33 (62%)**	**54,293**	**39,067**	**15,226**
Total	1920	33 (42%)	£ 191,921	£ 152,080	£ 39,841
	1921	29 (39%)	194,239	162,554	31,685
	1922	42 (53%)	169,677	142,417	27,260
	1923	53 (62%)	175,643	143,297	32,346
	1924	**50 (54%)**	**310,468**	**275,274**	**35,194**

PERCENTAGE OF HOSPITALS HAVING AN EXCESS OF:—

ORDINARY INCOME ... ... Shown in Black.

ORDINARY EXPENDITURE ... Shown in Red.



Illustrating Tables 41 and 42.

TABLE 42.

HOSPITALS HAVING AN **EXCESS OF ORDINARY EXPENDITURE** OVER ORDINARY INCOME.

Hospitals.	Year.	No. of Hospitals.	Total Ordinary Income.	Total Ordinary Expenditure.	Deficit.
Group A	1920	13 (72%)	£ 513,202	£ 610,976	£ 97,774
	1921	14 (82%)	501,237	584,376	83,139
	1922	14 (78%)	507,641	580,899	73,258
	1923	18 (95%)	555,468	638,788	83,320
	1924	**16 (84%)**	**439,713**	**520,205**	**80,492**
Group B	1920	12 (57%)	59,212	74,417	15,205
	1921	11 (55%)	60,804	71,967	11,163
	1922	9 (45%)	50,377	55,438	5,061
	1923	4 (20%)	20,712	23,233	2,521
	1924	**7 (33%)**	**37,216**	**40,352**	**3,136**
Group C	1920	20 (51%)	29,653	34,673	5,020
	1921	21 (55%)	29,590	36,182	6,592
	1922	14 (34%)	22,771	25,923	3,152
	1923	11 (23%)	13,724	16,247	2,523
	1924	**20 (38%)**	**27,495**	**33,543**	**6,048**
Total	1920	45 (58%)	£ 602,067	£ 720,066	£ 117,999
	1921	46 (61%)	591,631	692,525	100,894
	1922	37 (47%)	580,789	662,260	81,471
	1923	33 (38%)	589,904	678,268	88,364
	1924	**43 (46%)**	**504,424**	**594,100**	**89,676**

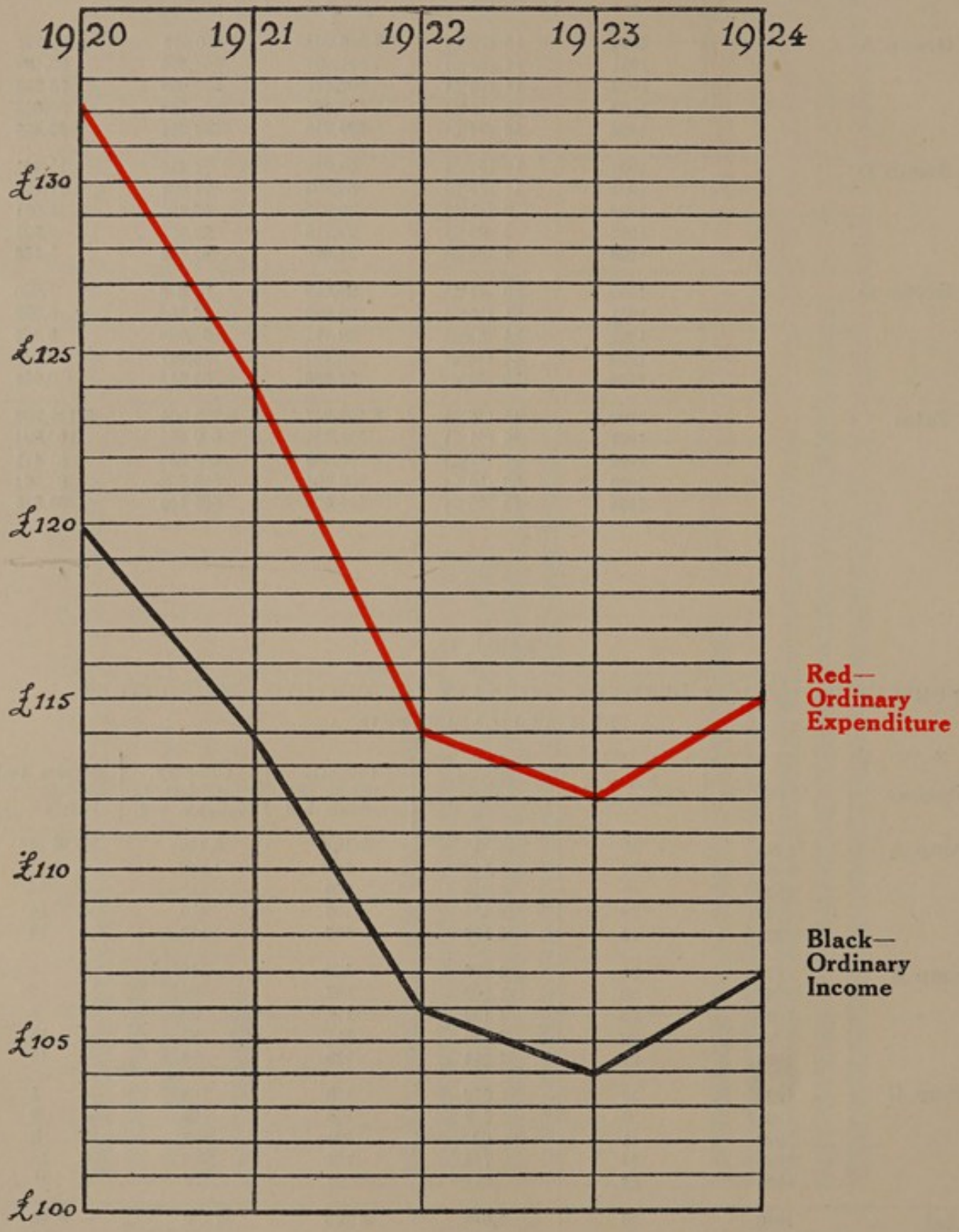
TABLE 43.

SURPLUS OR DEFICIT BETWEEN ORDINARY INCOME AND EXPENDITURE PER AVAILABLE BED.

Hospitals.	Year.	No. of Hospitals.	No. of available beds.	Ordinary Income per available bed.	Ordinary Expendtiure per available bed.	Surplus (+) or Deficit (—).
Group A ...	1920	18	4,918	£ 125*	£ 140*	— £ 15*
	1921	17	5,163	117	130	— 13
	1922	18	5,316	106	119	— 13
	1923	19	5,435	103	119	— 16
	1924	**19**	**5,495**	**108**	**123**	**— 15**
Group B ..	1920	21	1,136	109	112	— 3
	1921	20	1,142	103	106	— 3
	1922	20	1,152	107	99	+ 8
	1923	20	1,149	111	97	+ 14
	1924	**21**	**1,244**	**110**	**98**	**+ 12**
Group C ...	1920	39	552	103	104	— 1
	1921	38	582	108	105	+ 3
	1922	41	607	105	97	+ 8
	1923	47	742	104	89	+ 15
	1924	**53**	**844**	**97**	**86**	**+ 11**
Total ...	1920	78	6,606	£ 120	£ 132	— £ 12
	1921	75	6,887	114	124	— 10
	1922	79	7,075	106	114	— 8
	1923	86	7,326	104	112	— 8
	1924	**93**	**7,583**	**107**	**115**	**— 8**

* Calculated to the nearest £.

ORDINARY INCOME AND ORDINARY EXPENDITURE PER AVAILABLE BED OF THE TOTAL NUMBER OF HOSPITALS REVIEWED.



Illustrating Table 43.

TABLE 44.

ORDINARY INCOME AND ORDINARY EXPENDITURE OF GENERAL AND SPECIAL HOSPITALS SHOWN SEPARATELY.

Hospitals.	No. of Hosps.	Available beds.	Ordinary Income.		Ordinary Expenditure.		Surplus per available bed.	Deficit per available bed.
			Total.	Per available bed.	Total.	Per available bed.		
General Hospitals—								
Group A	15	4,796	£ 514,980	£ 107	£ 581,635	£ 121	—	£ 14
Group B ...	13	713	67,183	94	61,279	86	£ 8	—
Group C	44	688	58,892	86	55,751	81	5	—
Total	72	6,197	£ 641,055	£ 103	£ 698,665	£ 113	—	£ 10
Special Hospitals—								
Group A	4	699	£ 80,968	£ 116	£ 93,198	£ 133	—	£ 17
Group B	8	531	69,973	132	60,652	114	£ 18	—
Group C	9	156	22,896	147	16,859	108	39	—
Total	21	1,386	£ 173,837	£ 125	£ 170,709	£ 123	£ 2	—

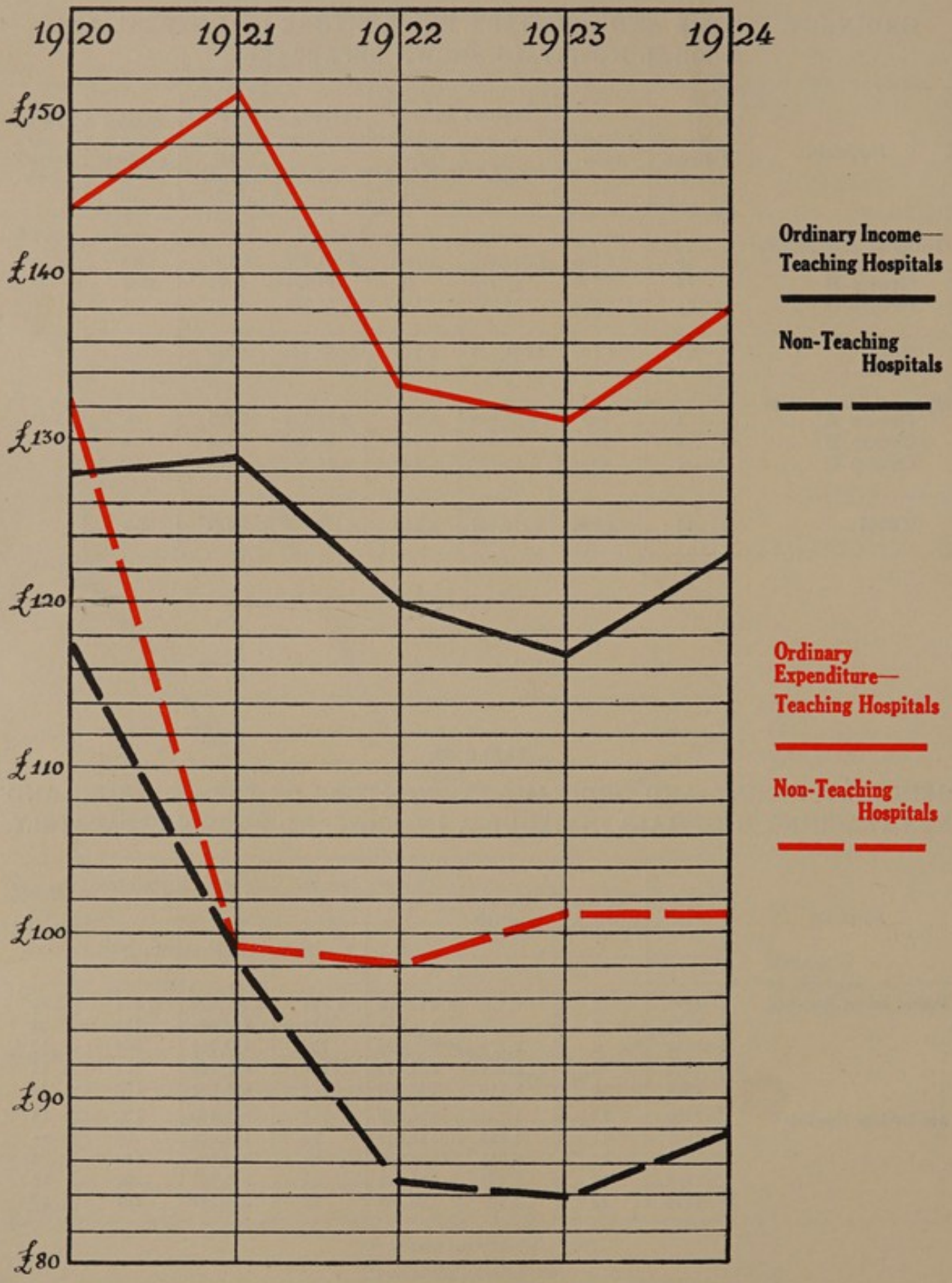
TABLE 45.

ORDINARY INCOME AND ORDINARY EXPENDITURE OF THE TEACHING AND NON-TEACHING HOSPITALS IN GROUP A IN SCOTLAND SHOWN SEPARATELY.

Hospitals.	Year.	No. of Hospitals.	No. of available beds.	Ordinary Income.		Ordinary Expenditure.		Deficit per available bed.
				Total.	Per available bed.	Total.	Per available bed.	
Medical School Hospitals	1920	6	3,193	£ 408,875	£ 128*	£ 460,628	£ 144*	£ 16*
	1921	6	3,172	410,478	129	479,602	151	22
	1922	6	3,172	381,593	120	422,355	133	13
	1923	6	3,214	375,620	117	420,683	131	14
	1924	**6**	**3,218**	**395,396**	**123**	**445,591**	**138**	**15**
Non-Teaching Hospitals	1920	12	1,725	204,009	118	228,466	132	14
	1921	11	1,956	194,642	99	193,325	99	—
	1922	12	2,144	181,709	85	209,082	98	13
	1923	13	2,221	185,623	84	223,737	101	17
	1924	**13**	**2,277**	**200,552**	**88**	**229,242**	**101**	**13**

* Calculated to the nearest £.

ORDINARY INCOME AND EXPENDITURE PER AVAILABLE BED OF HOSPITALS CONSTITUTING GROUP A.



Illustrating Table 45.

TABLE 46.

ORDINARY INCOME AND EXPENDITURE OF THE SIX HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN SCOTLAND.

Hospital.	Year.	Ordinary Income.	Ordinary Expenditure.	Ordinary Income per *occupied* bed.	Ordinary Expenditure per *occupied* bed.	Per *occupied* bed.	
						Deficit.	Surplus.
A	1920	£ 31,401	£ 33,388	£ 124·11	£ 131·96	£ 7·85	—
	1921	31,013	32,464	124·55	130·38	5·83	—
	1922	27,130	29,572	100·85	109·93	9·08	—
	1923	28,404	29,963	99·66	105·13	5·47	—
	1924	**29,173**	**29,923**	**98·23**	**100·75**	**2·52**	—
B	1920*	23,537	37,439	68·82	109·47	40·65	—
	1921*	34,632	42,631	106·23	130·77	24·54	—
	1922*	35,286	37,042	106·18	111·46	5·28	—
	1923	26,852	36,291	80·55	108·86	28·31	—
	1924	**31,805**	**36,267**	**89·53**	**102·09**	**12·56**	—
C	1920	133,354	130,668	152·40	149·33	—	£ 3·07
	1921	110,203	133,328	126·82	153·43	26·61	—
	1922	105,878	119,759	120·84	136·71	15·87	—
	1923	116,509	119,810	129·89	133·57	3·68	—
	1924	**113,915**	**127,537**	**126·15**	**141·24**	**15·09**	—
D	1920	105,920	115,419	155·76	169·73	13·97	—
	1921	105,359	116,982	154·89	171·98	17·09	—
	1922	101,315	104,813	154·00	159·31	5·31	—
	1923	94,176	107,598	130·28	148·84	18·56	—
	1924	**108,469**	**110,194**	**149·28**	**151·66**	**2·38**	—
E	1920	75,150	99,080	128·02	168·79	40·77	—
	1921	81,031	107,444	145·48	192·90	47·42	—
	1922	68,348	88,534	123·14	159·05	35·91	—
	1923	68,418	84,352	123·50	152·26	28·76	—
	1924	**69,784**	**97,537**	127·34	**177·99**	**50·65**	—
F	1920	39,513	44,634	145·80	164·70	18·90	—
	1921	48,240	46,753	170·46	165·20	—	5·26
	1922	43,636	42,635	152·57	149·07	—	3·50
	1923	41,261	42,669	143·27	148·16	4·89	—
	1924	**42,250**	**44,133**	**143·71**	**150·11**	**6·40**	—
Total ...	1920	£ 408,875	£ 460,628	£ 135·89	£ 153·09	£ 17·20	—
	1921	410,478	479,602	138·48	161·80	23·32	—
	1922	381,593	422,355	128·21	141·90	13·69	—
	1923	375,620	420,683	121·94	136·57	14·63	—
	1924	**395,396**	**445,591**	**126·57**	**142·64**	**16·07**	—

* Year ended 15th May.

SECTION 7.

ANALYSIS OF SOME OF THE SOURCES OF ORDINARY INCOME OF THE VOLUNTARY HOSPITALS IN SCOTLAND.

INVESTED FUNDS.

Since 1920 the Scottish Hospitals have increased their Invested Funds by more than £1,500,000, and to-day they can count upon £27.14 from the Interest upon Invested Funds towards the £115 required each year to maintain a bed. Income from this source has increased approximately 31 per cent. since 1920.

WORKMEN'S CONTRIBUTIONS.

Whatever may be the cause, this source of income remains almost stationary. It presents a striking contrast to the 50 per cent. growth in the English figures.

PATIENTS' CONTRIBUTIONS.

Income from this source remains almost stationary.

INCOME FROM PUBLIC SERVICES.

Less is received per available bed from this source than in England. Payments by the War Office, Admiralty and Ministry of Pensions are now almost a negligible quantity. All the other sources, except Venereal Diseases, have risen. The amount contributed by the Approved Societies is considerably higher than for the year 1923.

SUBSCRIPTIONS AND DONATIONS.

Subscriptions are down and Donations are up. Judging by the five years' record, Donations are well maintained, but Subscriptions show a continuous fall.

THE HOSPITAL BUDGET.

Making use of a similar tabulation to that on page 40 for the English Hospitals, the Scottish budget is as follows:—

	Hospitals in Scotland as a Whole.	*Medical School Group.*
Investments	£27 per available bed.	£28 per available bed.
Free Gifts	39	46
Workmen's Contributions and Contributory Schemes	23	34
Payments by or on behalf of Patients	14	10
	£103	£118
Towards meeting an Ordinary Expenditure of	£115	£138

TABLE 47.

INVESTED FUNDS AND THE INTEREST THEREFROM.

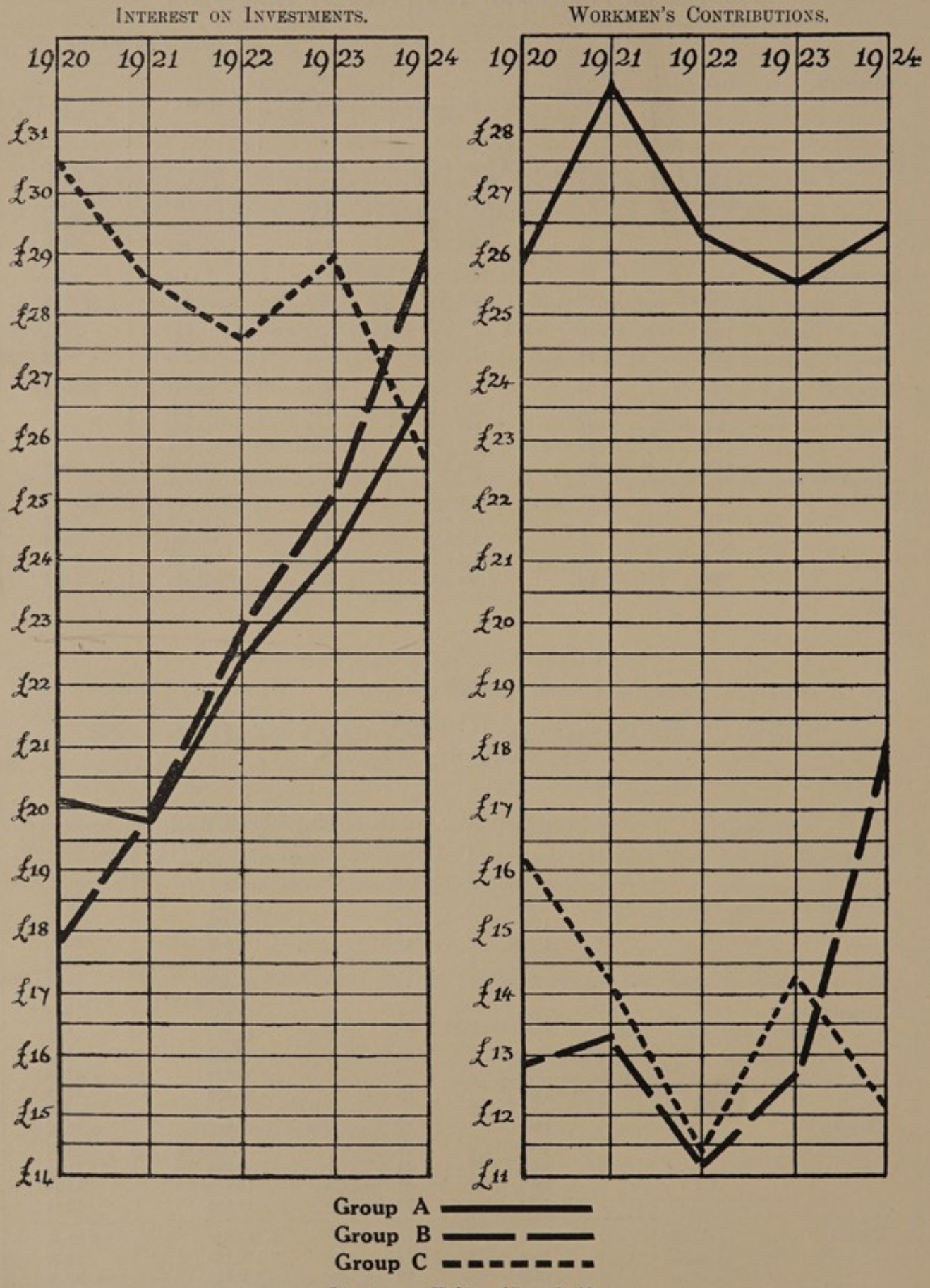
Hospitals.	Year.	No. of Hospitals.	Invested Funds.		Interest from Investments.	
			Total.	Per available bed.	Total.	Amount per available bed.
Group A ...	1920	18	£ 2,112,671	£ 430	£ 99,362	£ 20·20
	1921	17	2,157,373	418	102,363	19·83
	1922	18	2,473,707	465	119,457	22·47
	1923	19	2,720,189	500	131,625	24·22
	1924	**19**	**3,206,507**	**584**	**147,911**	**26·92**
Group B ...	1920	21	425,004	374	20,410	17·97
	1921	20	506,331	443	22,847	20·01
	1922	20	547,392	475	26,532	23·03
	1923	20	669,600	583	29,327	25·24
	1924	**21**	**864,684**	**695**	**36,171**	**29·08**
Group C ...	1920	39	362,447	658	16,915	30·64
	1921	38	370,799	637	16,663	28·63
	1922	41	357,502	589	16,803	27·68
	1923	47	480,613	648	21,551	29·04
	1924	**53**	**494,459**	**586**	**21,768**	**25·79**
Total ...	1920	78	£ 2,900,122	£ 422	£ 136,687	£ 20·69
	1921	75	3,034,503	441	141,873	20·60
	1922	79	3,378,601	478	162,792	23·01
	1923	86	3,870,402	528	182,503	24·91
	1924	**93**	**4,565,650**	**602**	**205,850**	**27·14**

TABLE 48.

WORKMEN'S CONTRIBUTIONS, HOSPITAL SATURDAY FUNDS, AND CONTRIBUTORY SCHEMES.

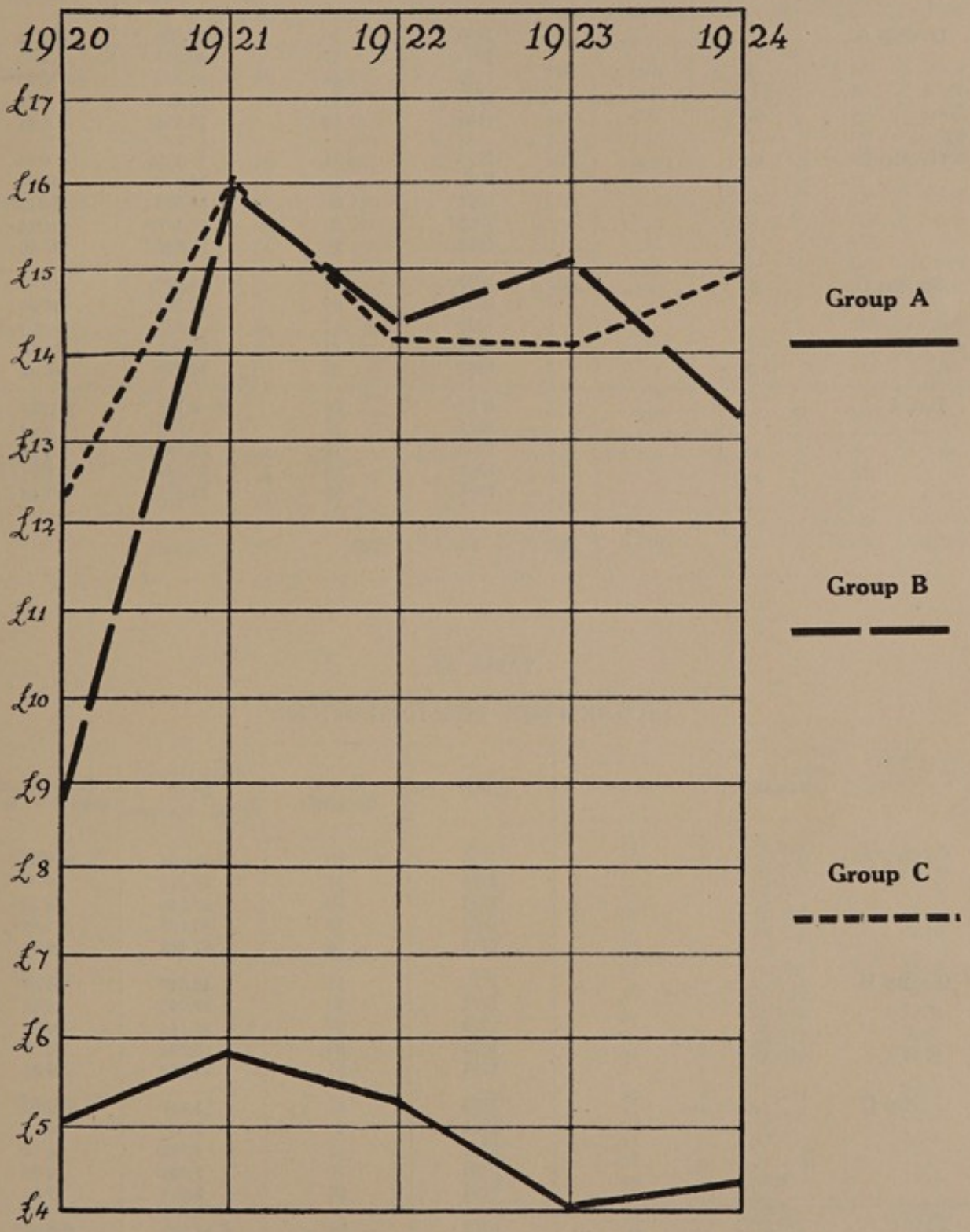
Hospitals.	Year.	No. of Hospitals.	Total Workmen's Contributions, Hospital Saturday Funds, and Contributory Schemes.	Amount per available bed.
Group A	1920	18	£ 127,991	£ 26·02
	1921	17	148,658	28·79
	1922	18	139,845	26·31
	1923	19	138,898	25·56
	1924	**19**	**145,435**	**26·47**
Group B	1920	21	14,637	12·88
	1921	20	15,216	13·32
	1922	20	12,995	11·28
	1923	20	14,643	12·74
	1924	**21**	**22,529**	**18·11**
Group C	1920	39	9,006	16·32
	1921	38	8,285	14·24
	1922	41	6,973	11·49
	1923	47	10,692	14·41
	1924	**53**	**10,220**	**12·11**
Total	1920	78	£ 151,634	£ 22·95
	1921	75	172,159	25·00
	1922	79	159,813	22·59
	1923	86	164,233	22·42
	1924	**93**	**178,184**	**23·50**

AMOUNT PER AVAILABLE BED DERIVED FROM:—



Illustrating Tables 47 and 48.

AMOUNT PER AVAILABLE BED DERIVED FROM PATIENTS' CONTRIBUTIONS.



Illustrating Table 49.

TABLE 49.

PATIENTS' CONTRIBUTIONS (including donations from "Grateful Patients").

Hospitals.	Year.	No. of Hospitals.	Total Patients' Contributions.	Amount per available bed.
Group A	1920	18	£ 25,155	£ 5·11
	1921	17	30,215	5·85
	1922	18	28,468	5·36
	1923	19	22,251	4·09
	1924	**19**	**24,215**	**4·41**
Group B	1920	21	10,176	8·96
	1921	20	18,277	16·00
	1922	20	16,652	14·45
	1923	20	17,417	15·16
	1924	**21**	**16,588**	**13·33**
Group C	1920	39	6,842	12·39
	1921	38	9,328	16·03
	1922	41	8,648	14·25
	1923	47	10,501	14·15
	1924	**53**	**12,672**	**15·01**
Total	1920	78	£ 42,173	£ 6·38
	1921	75	57,820	8·40
	1922	79	53,768	7·60
	1923	86	50,169	6·85
	1924	**93**	**53,475**	**7·05**

TABLE 50.

INCOME FROM PUBLIC SERVICES.

Hospitals.	Year.	No. of Hospitals.	Total Income from Public Services.	Amount per available bed.
Group A	1920	18	£ 32,435	£ 6·60
	1921	17	35,553	6·89
	1922	18	28,523	5·37
	1923	19	40,537	7·46
	1924	**19**	**37,123**	**6·76**
Group B	1920	21	18,813	16·56
	1921	20	11,903	10·42
	1922	20	12,144	10·54
	1923	20	13,894	12·09
	1924	**21**	**14,942**	**12·01**
Group C	1920	39	1,447	2·62
	1921	38	2,736	4·70
	1922	41	2,880	4·74
	1923	47	2,224	3·00
	1924	**53**	**2,605**	**3·09**
Total	1920	78	£ 52,695	£ 7·98
	1921	75	50,192	7·29
	1922	79	43,547	6·16
	1923	86	56,655	7·73
	1924	**93**	**54,670**	**7·21**

TABLE 51.

ANALYSIS OF THE SOURCES OF INCOME FROM PUBLIC SERVICES.

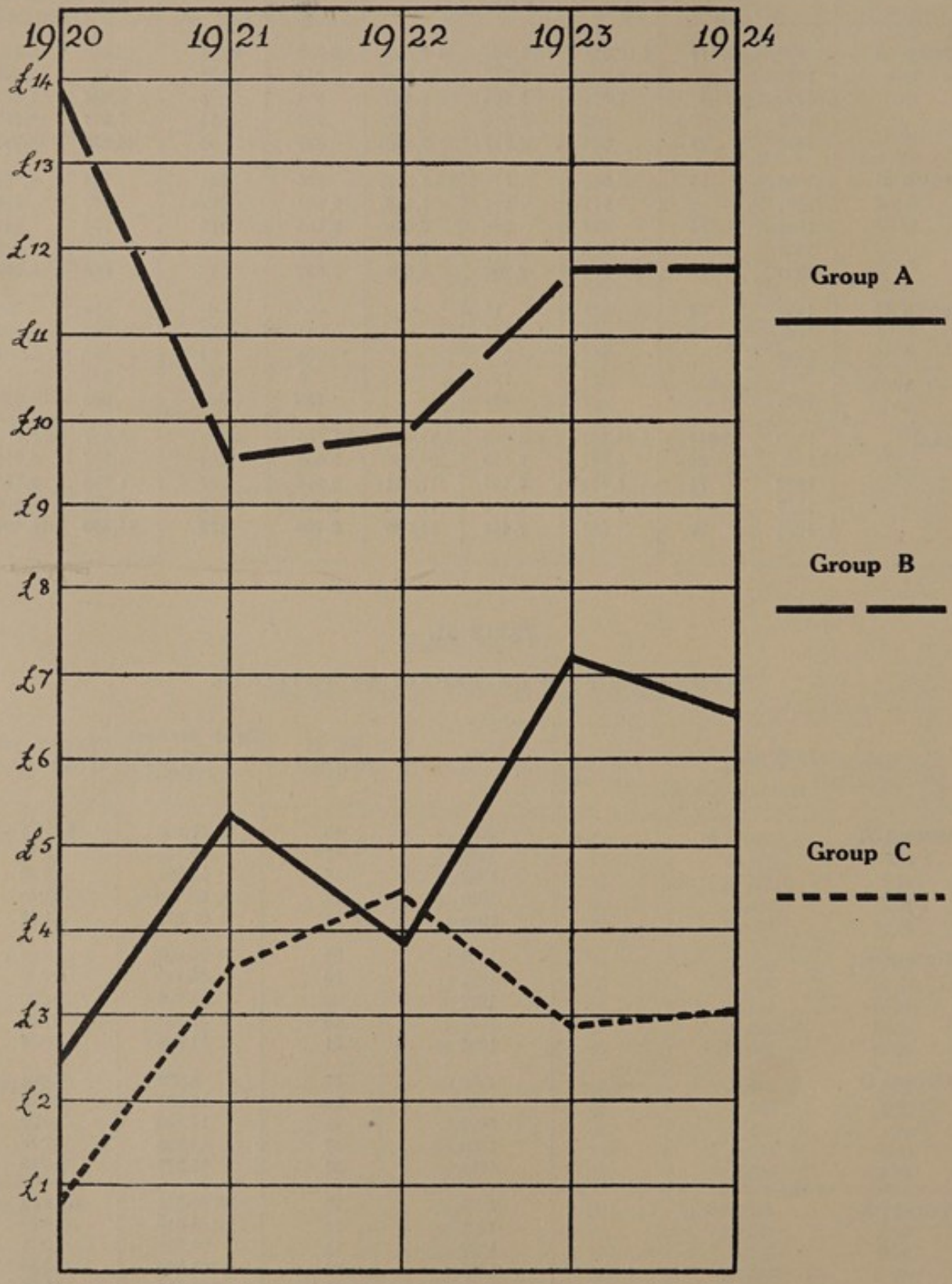
Hospitals.	Year.	War Office or Admiralty.	Ministry of Pensions.	Infant Welfare & Maternity Work.	Venereal Diseases.	Tuber-culosis Cases.	Education Authorities.	National Health Insurance Act.	Details not given.
Group A ...	1920	£ 558	£ 19,331	£ 1,628	£ 9,500	£ 309	£ 185	£ 401	£ 523
	1921	—	7,390	8,772	12,911	652	151	3,581	2,096
	1922	—	7,679	5,166	9,442	512	8	4,665	1,051
	1923	—	989	3,210	9,765	787	14	7,757	18,015
	1924	**27**	**621**	**4,717**	**7,690**	**659**	**15**	**10,651**	**12,743**
Group B ...	1920	25	2,949	370	7,527	835	254	123	6,730
	1921	2	971	515	7,496	2,139	290	171	319
	1922	74	626	522	8,049	2,130	105	178	460
	1923	—	362	2,122	7,848	2,299	—	651	612
	1924	**—**	**254**	**2,286**	**6,599**	**2,692**	**18**	**696**	**2,397**
Group C ...	1920	63	911	15	—	—	—	173	285
	1921	30	606	556	—	261	53	355	875
	1922	—	156	807	—	604	34	15	1,264
	1923	—	46	720	—	5	61	120	1,272
	1924	**—**	**7**	**451**	**—**	**139**	**146**	**503**	**1,359**
Total ...	1920	£ 646	£ 23,191	£ 2,013	£ 17,027	£ 1,144	£ 439	£ 697	£ 7,538
	1921	32	8,967	9,843	20,407	3,052	494	4,107	3,290
	1922	74	8,461	6,495	17,491	3,246	147	4,858	2,775
	1923	—	1,397	6,052	17,613	3,091	75	8,528	19,899
	1924	**27**	**882**	**7,454**	**14,289**	**3,490**	**179**	**11,850**	**16,499**

TABLE 52.

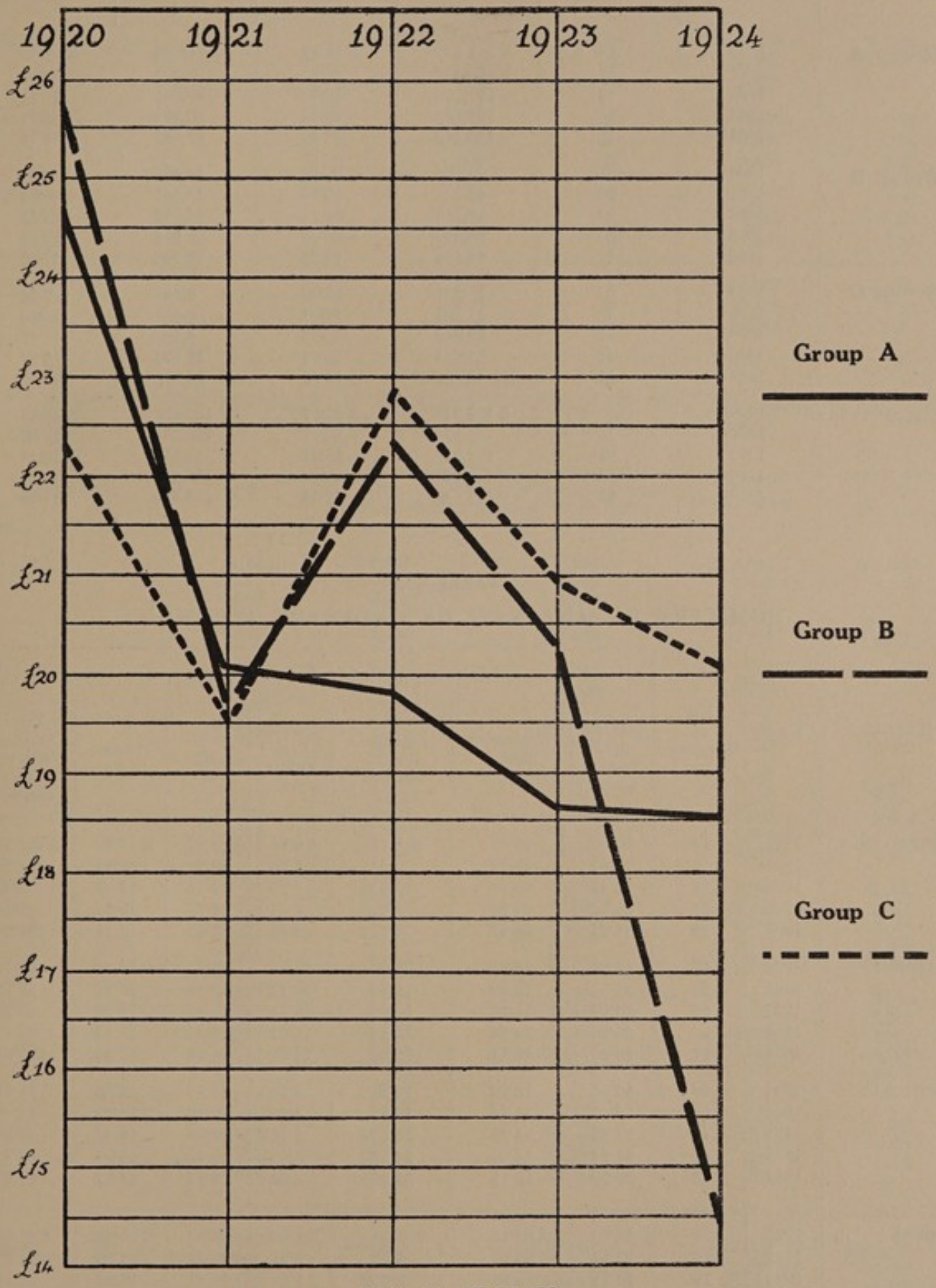
PAYMENTS BY OR ON BEHALF OF PATIENTS.

Hospitals.	Year.	No. of Hospitals.	Total payments by or on behalf of Patients.	Amount per available bed.
Group A	1920	18	£ 57,590	£ 11·71
	1921	17	65,768	12·74
	1922	18	56,991	10·72
	1923	19	62,788	11·55
	1924	**19**	**61,338**	**11·17**
Group B	1920	21	28,989	25·52
	1921	20	30,180	26·42
	1922	20	28,796	24·99
	1923	20	31,311	27·25
	1924	**21**	**31,530**	**25·34**
Group C	1920	39	8,289	15·01
	1921	38	12,064	20·73
	1922	41	11,528	18·99
	1923	47	12,725	17·15
	1924	**53**	**15,277**	**18·10**
Total	1920	78	£ 94,868	£ 14·36
	1921	75	108,012	15·69
	1922	79	97,315	13·75
	1923	86	106,824	14·58
	1924	**93**	**108,145**	**14·26**

AMOUNT PER AVAILABLE BED DERIVED FROM PUBLIC SERVICES (EXCLUDING WAR OFFICE, ADMIRALTY AND MINISTRY OF PENSIONS).



AMOUNT PER AVAILABLE BED DERIVED FROM ANNUAL SUBSCRIPTIONS.



Illustrating Table 53.

TABLE 53.

INCOME DERIVED FROM SUBSCRIPTIONS AND DONATIONS.

Hospitals.	Year.	No. of Hospitals.	Total Subscriptions.	Amount per available bed.	Total Donations (including Entertainments, etc.).	Amount per available bed.
Group A ...	1920	18	£ 121,335	£ 24·67	£ 86,528	£ 17·59
	1921	17	104,187	20·18	102,495	19·85
	1922	18	105,129	19·78	90,941	17·11
	1923	19	101,855	18·74	82,124	15·11
	1924	**19**	**102,143**	**18·59**	**99,489**	**18·11**
Group B ...	1920	21	29,265	25·76	14,058	12·37
	1921	20	22,605	19·79	18,551	16·24
	1922	20	25,816	22·41	15,573	13·52
	1923	20	23,378	20·35	21,985	19·13
	1924	**21**	**18,100**	**14·55**	**22,348**	**17·96**
Group C ...	1920	39	12,341	22·36	6,765	12·26
	1921	38	11,399	19·59	8,858	15·22
	1922	41	13,902	22·90	8,599	14·17
	1923	47	15,561	20·97	12,070	16·27
	1924	**53**	**16,981**	**20·12**	**14,575**	**17·27**
Total ...	1920	78	£ 162,941	£ 24·67	£ 107,351	£ 16·25
	1921	75	138,191	20·07	129,904	18·86
	1922	79	144,847	20·47	115,113	16·27
	1923	86	140,794	19·20	116,179	15·86
	1924	**93**	**137,224**	**18·10**	**136,412**	**17·99**

TABLE 54.

SUMMARY OF ANALYSIS OF ORDINARY INCOME.

Hospitals.	Year.	No. of Hospitals.	Amount per available bed received from :—						
			Interest from Investments.	Workmen's Contributions, etc.	Patients' Contributions.	Income from Public Services.	Subscriptions.	Donations.	Total Amount from the six sources.
Group A ...	1920	18	£ 20·20	£ 26·02	£ 5·11	£ 6·60	£ 24·67	£ 17·59	£ 100·19
	1921	17	19·83	28·79	5·85	6·89	20·18	19·85	101·39
	1922	18	22·47	26·31	5·36	5·37	19·78	17·11	96·40
	1923	19	24·22	25·56	4·09	7·46	18·74	15·11	95·18
	1924	**19**	**26·92**	**26·47**	**4·41**	**6·76**	**18·59**	**18·11**	**101·26**
Group B ...	1920	21	17·97	12·88	8·96	16·56	25·76	12·37	94·50
	1921	20	20·01	13·32	16·00	10·42	19·79	16·24	95·78
	1922	20	23·03	11·28	14·45	10·54	22·41	13·52	95·23
	1923	20	25·24	12·74	15·16	12·09	20·35	19·13	104·71
	1924	**21**	**29·08**	**18·11**	**13·33**	**12·01**	**14·55**	**17·96**	**105·04**
Group C ...	1920	39	30·64	16·32	12·39	2·62	22·36	12·26	96·59
	1921	38	28·63	14·24	16·03	4·70	19·59	15·22	98·41
	1922	41	27·68	11·49	14·25	4·74	22·90	14·17	95·23
	1923	47	29·04	14·41	14·15	3·00	20·97	16·27	97·84
	1924	**53**	**25·79**	**12·11**	**15·01**	**3·09**	**20·12**	**17·27**	**93·39**
Total ...	1920	78	£ 20·69	£ 22·95	£ 6·38	£ 7·98	£ 24·67	£ 16·25	£ 98·92
	1921	75	20·60	25·00	8·40	7·29	20·07	18·86	100·22
	1922	79	23·01	22·59	7·60	6·16	20·47	16·27	96·10
	1923	86	24·91	22·42	6·85	7·73	19·20	15·86	96·97
	1924	**93**	**27·14**	**23·50**	**7·05**	**7·21**	**18·10**	**17·99**	**100·99**

TABLE 55.

CONGREGATIONAL COLLECTIONS, INCLUDING HOSPITAL SUNDAY FUNDS.

Hospitals.	Year.	No. of Hospitals.	Total Congregational Collections.	Amount per available bed.
Group A	1922	18	£ 21,776	£ 4·10
	1923	19	23,424	4·31
	1924	**19**	**20,172**	**3·67**
Group B	1922	20	930	0·81
	1923	20	1,567	1·36
	1924	**21**	**1,954**	**1·57**
Group C	1922	41	1,261	2·08
	1923	47	1,326	1·80
	1924	**53**	**1,302**	**1·54**
Total	1922	79	£ 23,967	£ 3·39
	1923	86	26,317	3·59
	1924	**93**	**23,428**	**3·09**

TABLE 56.

SOME OF THE SOURCES OF ORDINARY INCOME OF THE SIX HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN SCOTLAND.

Hospitals.	Year.	Interest on Investments.	Workmen's Contributions, Hospital Saturday Funds, and Contributory Schemes.	Patients' Contributions.	Income from Public Services.
A	1920	£ 6,994	£ 3,576	£ 1,721	£ 2,975
	1921	7,115	3,589	1,643	2,636
	1922	6,526	3,437	1,543	2,733
	1923	6,811	3,413	1,611	4,274
	1924	**7,130**	**3,843**	**1,960**	**3,637**
B	1920*	9,802	3,754	1,545	—
	1921*	10,757	5,800	2,218	—
	1922*	9,948	4,670	6,315	—
	1923	9,602	4,693	1,347	—
	1924	**9,880**	**5,420**	**1,787**	**2,007**
C	1920	16,839	29,287	3,074	13,818
	1921	19,198	33,044	3,273	7,425
	1922	21,065	34,294	2,602	5,769
	1923	21,864	37,416	1,873	13,553
	1924	**23,427**	**37,950**	**2,155**	**9,288**
D	1920	**11,248**	30,934	1,378	2,481
	1921	11,884	30,939	2,398	3,561
	1922	14,690	29,030	2,539	3,061
	1923	16,939	28,953	2,033	3,071
	1924	**18,026**	**29,971**	**1,875**	**4,526**
E	1920	9,094	20,583	—	3,984
	1921	10,003	28,587	35	3,608
	1922	10,304	25,691	2,060	3,528
	1923	12,784	21,115	1,758	5,792
	1924	**16,550**	**23,161**	**1,451**	**4,150**
F	1920	7,154	8,534	654	—
	1921	7,996	12,087	1,463	401
	1922	10,391	12,121	352	926
	1923	13,181	10,247	949	526
	1924	**15,750**	**10,384**	**393**	—
Total	1920	£ 61,131	£ 96,668	£ 8,372	£ 23,258
	1921	66,953	114,046	11,030	17,631
	1922	72,924	109,243	15,411	16,017
	1923	81,181	105,837	9,571	27,216
	1924	**90,763**	**110,729**	**9,621**	**23,608**

* Year ended 15th May.

SECTION 8.

ANALYSIS OF THE PRINCIPAL EXPENDITURE OF THE VOLUNTARY

There has been a slight decrease in expenditure upon Fuel and Light in the Scotch Hospitals, such a decrease as might easily be brought about by a higher average temperature or more hours of sunlight during the year. In other respects the figures of expenditure in the A and B Group follow very much the same course as those in the English. Provisions, Surgery and

TABLE 57.

ANALYSIS OF THE PRINCIPAL ITEMS OF

Hospitals.	Year.	No. of Hospitals giving details.	No. of available beds.	Provisions.		Surgery and Dispensary.	
				Total.	Per available bed.	Total.	Per available bed.
Group A ...	1921	17	5,163	£ 171,371	£ 34·16	£ 71,232	£ 13·80
	1922	18	5,316	153,294	28·84	69,451	13·06
	1923	19	5,435	151,811	27·93	72,605	13·36
	1924	**19**	**5,495**	**157,595**	**28·68**	**77,508**	**14·11**
Group B ...	1921	15	899	30,145	33·53	10,751	11·96
	1922	19	1,068	27,813	26·04	11,033	10·33
	1923	19	1,065	26,265	24·66	11,244	10·56
	1924	**18**	**1,056**	**26,463**	**25·06**	**12,081**	**11·44**
Group C ...	1921	29	479	15,790	32·97	4,029	8·41
	1922	31	493	12,558	25·47	3,848	7·81
	1923	36	610	14,274	23·40	4,232	6·94
	1924	**42**	**680**	**16,093**	**23·67**	**4,286**	**6·30**
Total ...	1921	61	6,541	£ 222,306	£ 33·99	£ 86,012	£ 13·15
	1922	68	6,877	193,665	28·16	84,332	12·26
	1923	74	7,110	192,350	27·05	88,081	12·39
	1924	**79**	**7,231**	**200,151**	**27·68**	**93,875**	**12·98**

ITEMS OF ORDINARY HOSPITALS IN SCOTLAND.

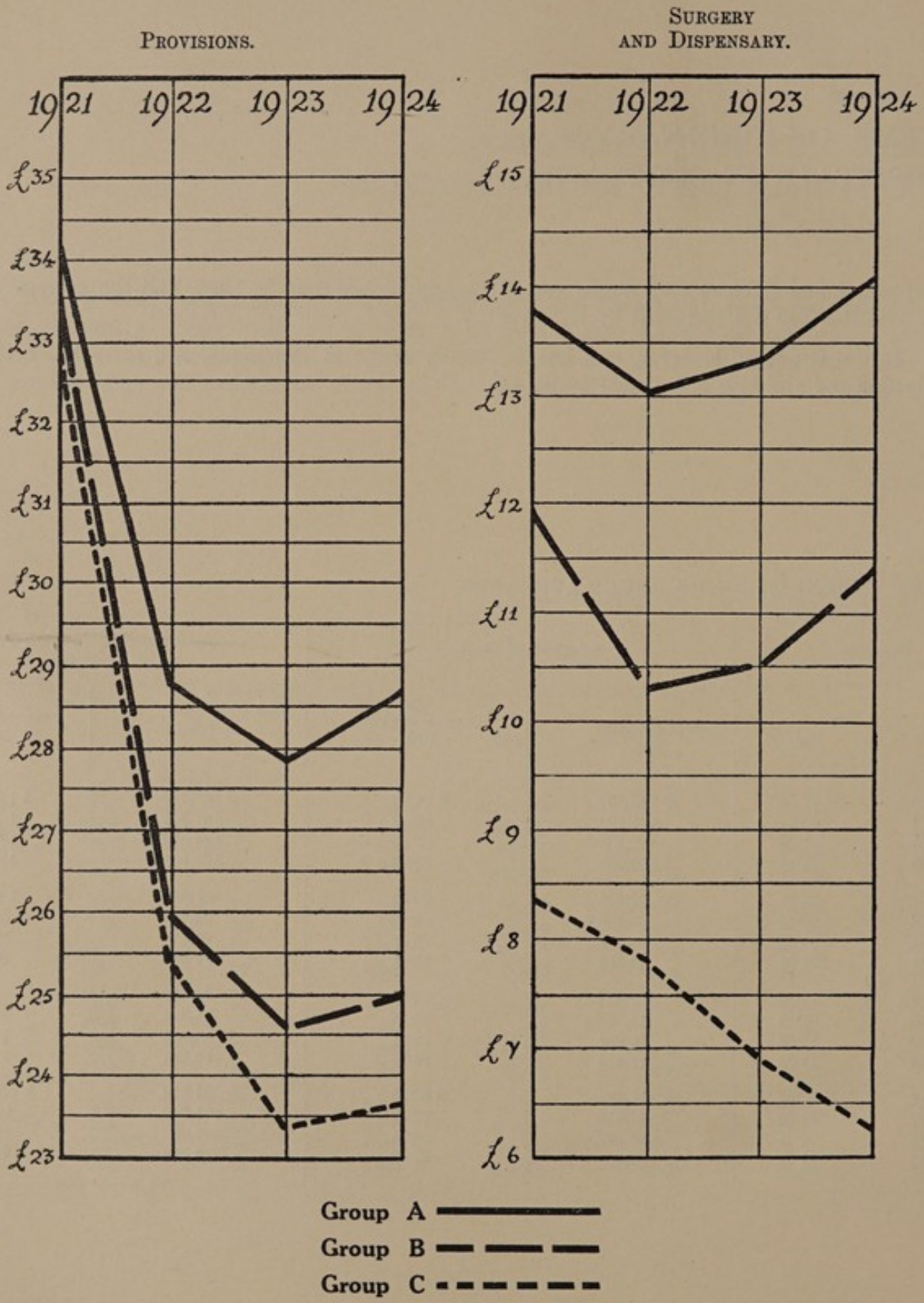
Dispensary and Salaries and Wages are all slightly higher than in 1923, and the average cost per available bed has increased by just over £2.

In the C Group, however, cost has decreased, except in Provisions, and there has been a reduction per available bed of just under £2.

ORDINARY EXPENDITURE BY GROUP AVERAGES.

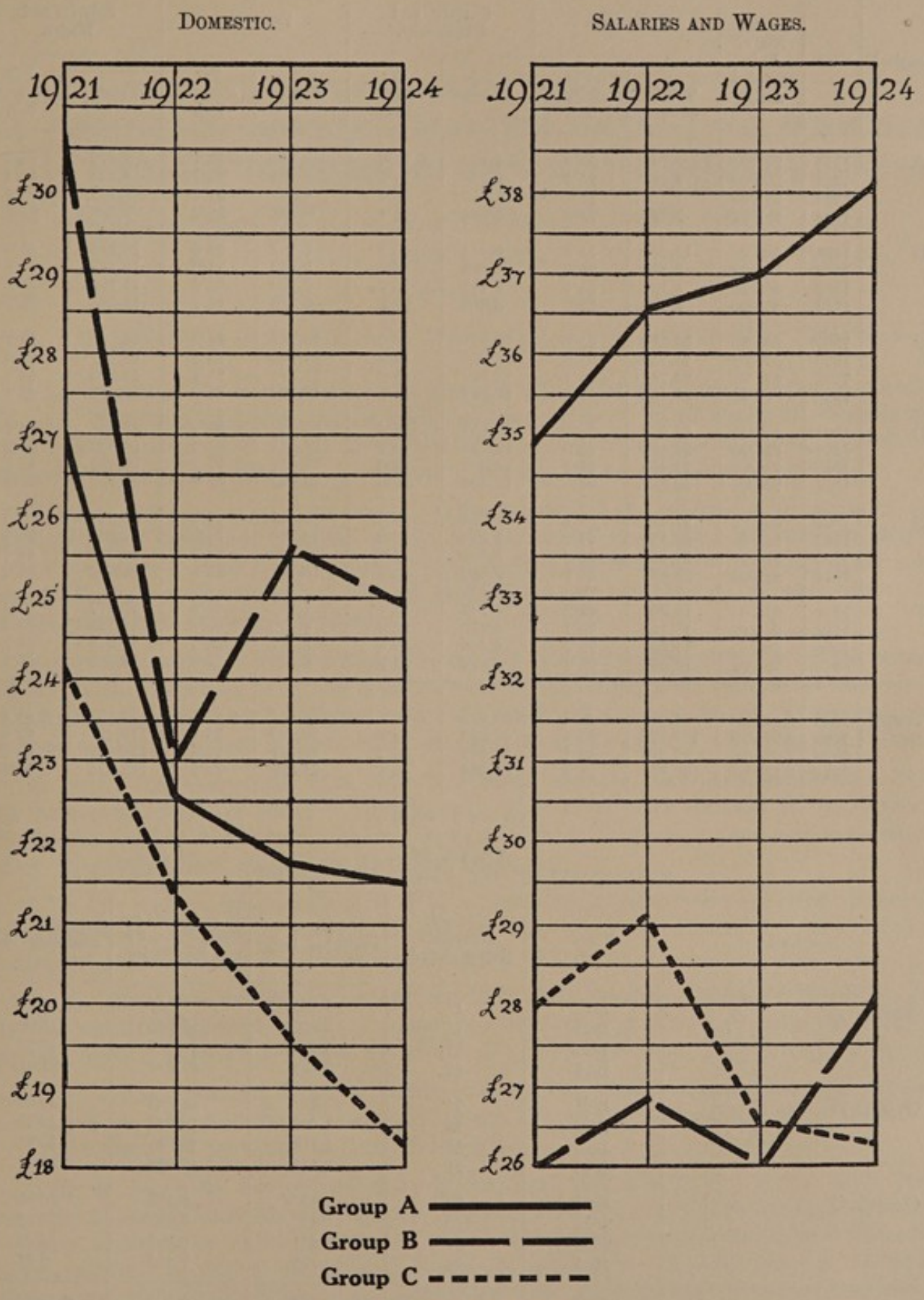
Domestic.		Salaries and Wages.		Total Expenditure under the four headings.	
Total.	Per available bed.	Total.	Per available bed.	Total.	Per available bed.
£ 139,518	£ 27·02	£ 180,635	£ 34·99	£ 567,756	£ 109·97
120,174	22·61	194,522	36·59	537,441	101·10
118,615	21·82	201,335	37·05	544,366	100·16
118,463	**21·56**	**209,920**	**38·20**	**563,486**	**102·55**
27,605	30·71	23,409	26·04	91,910	102·24
24,703	23·13	28,708	26·88	92,257	86·38
27,344	25·68	27,779	26·08	92,632	86·98
26,361	**24·96**	**29,684**	**28·11**	**94,589**	**89·57**
11,593	24·20	13,441	28·06	44,853	93·64
10,550	21·40	14,388	29·18	41,344	83·86
11,990	19·66	16,234	26·61	46,730	76·61
12,468	**18·34**	**17,904**	**26·33**	**50,751**	**74·64**
£ 178,716	£ 27·32	£ 217,485	£ 33·25	£ 704,519	£ 107·71
155,427	22·60	237,618	34·55	671,042	97·57
157,949	22·21	245,348	34·51	683,728	96·16
157,292	**21·75**	**257,508**	**35·62**	**708,826**	**98·03**

EXPENDITURE PER AVAILABLE BED.



Illustrating Table 57.

EXPENDITURE PER AVAILABLE BED.



Illustrating Table 57.

TABLE 58.

ANALYSIS OF THE PRINCIPAL ITEMS OF ORDINARY EXPENDITURE IN THE SIX HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN SCOTLAND.

Hospital.	Year.	Average No. of beds occupied daily.	Provisions.		Surgery and Dispensary.		Domestic.		Salaries and Wages.	
			Total.	Per *occupied* bed.	Total.	Per *occupied* bed.	Total.	Per *occupied* bed.	Total.	Per *occupied* bed.
A ...	1921	249·00	£ 8,768	£ 35·2	£ 3,135	£ 12·6	£ 7,566	£ 30·4	£ 8,776	£ 35·2
	1922	269·00	6,949	25·8	3,369	12·5	5,956	22·2	8,894	33·1
	1923	285·00	7,184	25·2	3,810	13·4	6,081	21·3	8,997	31·6
	1924	**297·00**	**7,226**	**24·3**	**3,604**	**12·1**	**6,282**	**21·2**	**9,282**	**31·3**
B ...	1921*	326·00	11,703	35·9	6,644	20·4	9,397	28·8	10,915	33·5
	1922*	332·33	9,606	28·9	4,568	13·7	8,959	27·0	10,472	31·5
	1923	333·36	8,125	24·4	3,618	10·9	7,550	22·6	11,991	36·0
	1924	**355·26**	**8,495**	**23·9**	**3,616**	**10·2**	**6,330**	**18·1**	**13,055**	**36·7**
C ...	1921	869·00	30,585	35·2	13,891	16·0	27,087	31·2	43,238	49·7
	1922	876·00	24,150	27·6	12,810	14·6	20,189	23·0	41,677	47·6
	1923	897·00	22,761	25·4	14,209	15·8	18,904	21·1	41,390	46·1
	1924	**903·00**	**24,402**	**27·0**	**16,547**	**18·3**	**19,774**	**21·9**	**44,632**	**49·4**
D ...	1921	680·20	34,076	50·1	13,179	19·4	26,696	39·2	32,888	48·4
	1922	657·90	28,872	43·9	12,784	19·4	19,471	29·6	33,025	50·2
	1923	722·90	28,678	39·7	13,413	18·6	19,687	27·2	35,509	49·1
	1924	**726·60**	**29,282**	**40·6**	**14,419**	**19·8**	**19,667**	**27·1**	**36,179**	**49·8**
E ...	1921	557·00	27,924	50·1	10,753	19·3	24,577	44·1	24,242	43·5
	1922	555·00	26,014	46·9	9,352	16·9	18,894	34·0	30,252	54·5
	1923	554·00	21,571	38·9	8,809	15·9	13,432	24·2	24,731	44·6
	1924	**548·00**	**20,875**	**38·1**	**9,080**	**16·6**	**13,701**	**25·0**	**24,667**	**45·0**
F ...	1921	283·00	13,925	49·2	4,745	16·8	8,292	29·3	12,972	45·8
	1922	286·00	11,181	39·1	4,412	15·4	6,479	22·7	14,107	49·3
	1923	288·00	11,037	38·3	4,444	15·4	6,477	22·5	14,319	49·7
	1924	**294·00**	**10,997**	**37·4**	**5,198**	**17·7**	**6,845**	**23·3**	**14,660**	**49·9**
Total	1921	2,964·20	£ 126,981	£ 42·8	£ 52,347	£ 17·7	£ 103,615	£ 35·0	£133,031	£ 44·9
	1922	2,976·23	106,772	35·5	47,295	15·9	79,948	28·1	138,427	48·9
	1923	3,080·26	99,356	32·3	48,303	15·7	72,131	23·4	136,937	44·5
	1924	**3,123·86**	**101,277**	**32·4**	**52,464**	**16·8**	**72,599**	**23·2**	**142,475**	**45·6**

* Year ended 15th May.

TABLE 59.

EXPENDITURE ON FUEL AND LIGHT.

Hospitals.	Year.	No. of Hospitals giving details.	No. of available beds.	Expenditure on Coal, Coke, Gas and Electricity.	Expenditure per available bed.
Group A	1921	17	5,163	£ 97,514	£ 18·89
	1922	15	3,880	53,542	13·80
	1923	17	4,102	54,707	13·34
	1924	**18**	**5,131**	**67,200**	**13·10**
Group B	1921	16	937	14,703	15·69
	1922	18	1,032	12,543	12·15
	1923	19	1,113	13,595	12·21
	1924	**21**	**1,134**	**13,966**	**12·32**
Group C	1921	29	479	6,491	13·55
	1922	30	476	5,513	11·58
	1923	37	621	6,886	11·09
	1924	**43**	**721**	**7,196**	**9·98**
Total	1921	62	6,579	£ 118,708	£ 18·04
	1922	63	5,388	71,598	13·29
	1923	73	5,836	75,188	12·88
	1924	**82**	**6,986**	**88,362**	**12·65**

THE AUXILIARY HOSPITAL.
ITS FINANCIAL ASPECT AND THE EXTENT TO WHICH IT CAN RELIEVE PRESSURE UPON PARENT HOSPITAL BEDS.

A Paper read before the Incorporated Association of Hospital Officers, London, 15th May, 1925.

BY

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The decision of the correct title to be given to this paper has been a matter of no small difficulty. We have tried and rejected many, and we are not even satisfied with the one now chosen. For this reason it will be best to describe in more detail what we mean when we are talking about Auxiliary Hospitals, or Recovery Homes, as they are sometimes called.

The outstanding characteristic of an Auxiliary Hospital, by contrast with what we may conveniently call the parent Hospital, is that it is an institution to which patients can properly be sent for whom it is no longer necessary and, in fact, uneconomic, to continue under treatment in the parent Hospital; but who for medical reasons are unfit to be sent either to a Convalescent Home, or their own homes.

Generally speaking, Auxiliary Hospitals are best situated in the country or at the seaside, and are much less costly from the point of view of buildings, staff, equipment and cost of maintenance than the parent Hospital; although, on the other hand, for similar reasons, they are more costly in all these respects than what are commonly called " Convalescent Homes."

To make the comparison with both the parent Hospital and the Convalescent Home still more clear, we have added to this paper a schedule of cases showing the type of case admitted to such an institution, together with a table of the average period of treatment in parent Hospitals before transfer to Auxiliary Hospitals.

With this preliminary statement we hope we have made quite clear the type of institution which forms the subject of this paper, and we now desire to discuss the value of these institutions as a factor in the Voluntary Hospital service.

In the first place we would remind you that there are two Voluntary Hospital Commissions sitting at present, one in England and the other in Scotland, with the object of reporting upon a reference from the Minister of Health, which is in the following terms :—

> " The Voluntary Hospital Commission are requested to enquire into and to report upon the extent of the additional Voluntary Hospital accommodation required and the best means of providing and maintaining it."

It is no secret to any of you that, in England and Wales, practically every Local Voluntary Hospital Committee has reported that additional Voluntary Hospital accommodation is needed, although as might be expected, the kind of institution and the additional number of beds required, as well as the type of disease for which there is a deficiency of accommodation, vary very considerably. The outstanding fact which emerges from a consideration of all these reports is that some thousands of additional Hospital beds are said to be required in England and Wales, taken as a whole.

Assuming for the moment that the data upon which this calculation is formed are correct and that in fact there is a proved need for several thousand more beds in our Voluntary Hospitals, it is surely well worth while making a very careful enquiry into the question as to which is the cheapest way in which this additional accommodation can be provided from the point of view of :—

(*a*) Capital expenditure.

(*b*) Cost of maintenance.

(*c*) The best interests of the patient.

At this point we would draw your attention to the fact that in Scotland it has been reported in the Press that quite a number of witnesses in giving evidence before the Commission have recommended the provision of Auxiliary Hospitals, in order to relieve the pressure upon the parent Hospitals, as at least well worthy of consideration. On the other hand, in England one of the largest and most important of the local Voluntary Hospital Committees has expressed the following view :—

> " The provision of recovery beds, where patients receive hospital treatment and not convalescent home treatment, does increase the number treated to approximately the same extent as the provision of an equal number of additional beds on the site of the parent Hospital. The idea that extension by recovery beds is cheaper than extension by hospital beds rests almost wholly on an illusion. Recovery beds may cost £2 2s. a week, while beds in the parent Hospital cost £5 5s. a week. But this is only because the cost of a hospital bed, where there are no recovery beds, includes all the stages of treatment, whereas, if there is a recovery branch, the hospital beds are confined to the more expensive stages and the recovery beds to the less expensive. Thus, if the cost of the single institution averages £4 a week, this is made up of so many days averaging (say) £6 a week, so many averaging £5, so many averaging £3, and so many averaging £2. If the whole of the days averaging £3 and £2 a week are spent at a recovery branch, the average cost at that branch may well be between £2 and £3 a week, while the average cost at the parent Hospital rises to between £5 and £6. But this does not mean that the combined average cost has altered in the least.
>
> " There may be a saving in capital expenditure and in some items of maintenance, but, on the other hand, there will be some extra cost of separate administration and of transport.
>
> " The advantage of a recovery branch, as compared with extension on the hospital site, lies, therefore, solely in the benefit to the individual patients, not in any increase in the number treated for the same amount of money."

It will be seen from a study of the paragraph quoted that this Committee is of the opinion that, altogether apart from questions of capital expenditure and extra cost of separate administration and transport, there would be no economy in so far as *maintenance* is concerned, if the additional Hospital accommodation needed is provided by means of Auxiliary Hospitals rather than by the addition of a similar number of parent Hospital beds.

Before proceeding to the consideration of the comparative cost of maintenance, there are two important questions which should be borne in mind, viz. :—

(1) To what extent are beds in parent Hospitals *now* occupied by patients who have reached a stage in their treatment when they may be expected to progress towards recovery equally well, if not indeed more rapidly, at Auxiliary Hospitals situated in the country or at the seaside.

(2) To what extent would there still be a real shortage of beds in our parent Hospitals, if all those patients found suitable on medical grounds for transfer to Auxiliary Hospitals were so transferred at the earliest possible date.

We submit that before even an approximate estimate of the *real* shortage of beds in our Voluntary Hospitals in this country can be arrived at, these two questions must be answered.

There should be no difficulty in arriving at an answer to the first question.

We shall probably all agree that if a careful investigation of all the beds occupied in our General and Special Hospitals is made by competent persons, it will be found that there are always some beds occupied by patients for whom the parent Hospital has done all that can reasonably be asked of it. They have not been discharged for one of two reasons :—

(1) The patient is not yet really fit enough to go direct home or to a Convalescent Home.

(2) There is no other suitable institution to which the patient can be sent.

All of you are familiar with this fact and will agree that the Convalescent Home is an institution which, as a rule, is not built, equipped, or staffed, in such a way as to be able to relieve the parent Hospital of the type of case at the stage of treatment which we have in mind. If then it be true that there is a certain wastage or uneconomic use of beds in the parent hospitals, and this wastage can be reduced by the provision of an equally suitable type of institution, called an Auxiliary Hospital, then it is surely of first-rate importance to make a careful enquiry into the accuracy of the statement that " the idea that extension by Recovery beds is cheaper than extension by Hospital beds rests almost wholly on an illusion."

The second question is more difficult to answer. In each area the conditions vary sometimes considerably and calculations based upon two, three, or four beds per 1,000 of the population, have a very limited value. Waiting lists, however carefully kept, although useful, cover a comparatively small portion of the ground. Experience has taught us all that in cases where additional Hospital accommodation of one kind or another is provided, a most surprising demand for such accommodation springs up from all kinds of unexpected quarters.

Consideration also has to be given to the extent to which Public Health Authorities and Poor Law Guardians in various parts of the country are, or are not, fulfilling their statutory obligations. In short, there are so many different points to be considered in each area before a satisfactory answer can even be attempted to this question, that we put it aside entirely for the purposes of this paper and proceed at once to consider the most important question which we are here to discuss this morning, viz. :—

Is it True to Say that the Idea that Extension by Recovery Beds is Cheaper than Extension by Hospital Beds Rests Wholly on an Illusion?

This is the considered opinion of a committee which represents an area containing some 12,000 to 13,000 beds, and in which there is an estimated shortage of 2,000 beds.

There are two methods under consideration by which this shortage can be met :—

Scheme A. By adding, to the existing Hospitals, wards containing beds to the required number.

Scheme B. By providing 2,000 beds in Homes of Recovery in neighbouring country districts.

We propose to examine these alternative methods in some detail.

1. An examination of the sums spent upon the various items that go to make up the cost of a Hospital patient—after deducting out-patient costs—gives the following percentages—approximately :—

Provisions	22 per cent.
Surgery and Dispensary	9 per cent.
Domestic	22 per cent.
Salaries and Wages	36 per cent.
Establishment	6 per cent.
Miscellaneous Administration, etc....	5 per cent.
	100 per cent.

2. A Hospital of 300 beds, fully occupied, and in which the average cost of each in-patient is £3 per week, spends £46,800 per annum, in the following proportions :—

Provisions, £10,296; Surgery and Dispensary, £4,212; Domestic, £10,296; Salaries and Wages, £16,848; Establishment, £2,808; Miscellaneous and Administration, £2,340.

The cost per patient per week is therefore :—

Provisions, 13·20 shillings; Surgery and Dispensary, 5·40 shillings; Domestic, 13·20 shillings; Salaries and Wages, 21·60 shillings; Establishment, 3·60 shillings; Miscellaneous and Administration, 3·00 shillings.

3. If we assume that in this Hospital each patient stays in three weeks, we shall have in the year :—

5,200 first week treatments.
5,200 second week treatments.
5,200 third week treatments.
15,600

As the proposed increase in beds in the area referred to is approximately 15 per cent. of the total accommodation, extension by Recovery Homes, rather than by the addition of Hospital beds, would reduce the number of third week treatments and increase the number of first and second week treatments. The yearly weeks' treatments in the 300-bedded Hospital would then be as follows :—

5,980 first week treatments.
5,980 second week treatments.
3,640 third week treatments.
15,600

4. If it is agreed that the first week treatment is more expensive than the third in the case of a considerable number of Hospital patients, it becomes necessary to consider what adjustments are reasonable.

Provisions.—Although there are grounds for believing that in the matter of Provisions a patient in his *third* week is more expensive than in his *first* week, we have assumed an equality of weekly cost and made no adjustment.

Surgery and Dispensary.—The effect of a rapid passage of patients through the beds would most naturally be looked for in this item. We have assumed that the relative cost

of the first, second, and third week treatments are as 5 : 2 : 1, and we have allotted 10·125 shillings to the first week, 4·050 shillings to the second, and 2·025 shillings to the third.

We are of opinion that this assumption errs upon the high side.

A careful examination of the figures in the statistical tables of the King Edward's Hospital Fund for London, and in the corresponding tables for the Provincial Hospitals, reveals no clear relationship between the length of residence of a patient in a Hospital and the cost per occupied bed of " Surgery and Dispensary."

The figures for the Hospitals with Medical Schools in London, the Provinces, and Scotland, showing the excess, or the deficiency on the average in " Surgery and Dispensary," are given in Appendix IV.

Out of all the other items which go to make up the weekly cost of a patient, it is difficult to believe that any, except Laundry and Nursing, are materially affected by the *stage* of treatment of the patient. In confirmation of this, we would draw attention to the fact that in a Hospital built, staffed and equipped to treat a certain number of patients, every bed under that number left unoccupied, costs approximately 75 per cent. of the cost of an occupied one. The stage of treatment of a patient can, therefore, only affect something less than 25 per cent. of the average weekly cost, and it is not unreasonable to conclude that an allowance for " Surgery and Dispensary," " Laundry " and " Nursing," will cover practically everything in which a first week patient is more expensive than a third week patient.

If the Uniform System of Accounts were drawn up in such a way as to show the several costs of each service rendered, the task of estimation would be a comparatively simple one. This, however, is not so, and it is necessary to attempt to arrive at an estimate of a reasonable allowance for " Laundry " and " Nursing " by a method that differs from that used in estimating " Surgery and Dispensary."

Laundry.—There are sufficient data to justify the estimate of laundry costs at approximately 4s. per week per patient. There are also data to justify the estimate that 1s. per week is sufficient to allow for the extra cost of a first week treatment over that of a third week treatment. We have, therefore, added this amount to the cost of the additional first week treatments at the main Hospital involved in Scheme B.

Nursing.—A similar method has been employed in dealing with the allowance for the extra cost of Nursing. On the assumption that a ward of 24 beds, filled with patients in the first and second week of treatment, would require one nurse more than a ward filled with first, second and third week patients, and allowing £150 per annum for the cost of a nurse, we have added a sum of £450 for the three extra nurses that would be required for the 90 beds devoted under Scheme B to the treatment of patients in the earlier stages, and that we may not minimise the possible extra cost entailed in the first days of treatment, we have added the whole of the extra cost to the first week.

The adjusted figures of weekly cost thus appear as :—

		£	s.	d.
First week	66·360 shillings	3	6	4½
Second week	58·650 shillings	2	18	7¾
Third week	56·625 shillings	2	16	7½

5. The effect, therefore, on the cost per patient of transferring 15 per cent. of the patients, most of whom would be in the third week of treatment, to a Recovery Home, works out as follows :—

		£	s.	d.
5,980	first weeks of treatment	19,841	15	6
5,980	second weeks of treatment	17,536	7	0
3,640	third weeks of treatment	10,305	15	0
15,600		£47,683	17	6
Less 15,600	weeks at £3 per week	£46,800	0	0
	Increased Cost	£883	17	6

In other words, the cost of each in-patient per week becomes £3 1s. 1½d. in place of £3.

It therefore appears that the effect of converting 15 per cent. of the beds of a Hospital from a three week to a two week service upon *the average weekly cost of each patient*, is by no means so great as is suggested in the paragraph which we have quoted.

If our conclusion is correct and we apply it to the area in question, the costs under Scheme A and B work out in this way:—

Scheme A. *Per week.*

13,000 existing beds.
2,000 additional Hospital beds.

15,000 at an average cost of £3 per patient per week ... £45,000 0 0

Scheme B.

	£	s.	d.			
13,000 existing beds at a cost of £3 1s. 1½d. per patient per week	39,731	5	0			
2,000 beds in Recovery Homes at £2 per patient per week	4,000	0	0			
				43,731	5	0
Or a weekly saving of ...				£1,268	15	0

Equal to £65,975 per annum.

If in place of a weekly average cost of £3 in the main Hospital, a weekly average cost of £3 10s. is assumed, the saving on Scheme B, as compared with Scheme A, amounts in each week to £2,214 11s. 8d., or £115,158 6s. 8d. per annum.

Up to this point the line of argument has been confined to figures based upon such data as are available. So far as they go, they tend to show that there is at least *prima facie* evidence in favour of the "idea" which has been described as illusory. We are indeed unable to accept the view that expenditure at a parent Hospital rises with the rapidity of the passage of the patients through its beds at such a rate as to balance the lower cost of the beds in an Auxiliary Hospital. We hold that the unavoidable expenditure, at every large and expensively staffed and equipped General Hospital, that is altogether independent of the stage of treatment of a patient, or even of the occupation of the bed at all, far outweighs any differences in cost between first, second, or third weeks of treatment.

At the same time we are content to leave in abeyance judgment on this aspect of Auxiliary Hospitals, and for this reason: that even if it should be true that the "idea" to which we have so often referred, rests on an illusion, it by no means follows that extension by Auxiliary Hospitals is an economically illusory proposition.

The Economic Use of Parent Hospital Beds.

It has been well said, by the Committee already referred to, that "the addition of a Recovery Branch, centres in the parent Hospital a larger number of patients who need

expensive methods of diagnosis, operations, and other early stages of treatment, and thus enables fuller use to be made of the highly specialised staff and apparatus, thereby reducing cost and increasing efficiency of service. But this result is only produced if the staff and apparatus are not already fully employed, and in that case would be produced by the addition of beds on the Hospital site."

What meaning, however, are we to attach to the words, " fully employed "? for upon this depends almost entirely the case for or against the Auxiliary Hospital. The modern parent Hospital is so situated, built staffed, and equipped, that cost is only reduced to a minimum and efficiency raised to a maximum, when it is engaged upon work of a highly specialised character. Any individual bed, therefore, occupied by a patient, who no longer requires the services which only such a Hospital can give, is being used uneconomically. The bed is employed, it is true, but not *fully employed* in the economic sense. Can it be said of any large General Hospital that there are no patients in its beds who could not, without detriment to their treatment, be transferred to Auxiliary Hospitals if such existed?

In the twelve large General Hospitals in London with Medical Schools, the average number of days each patient was resident during 1923 was 19.57, and the variations ranged from 26.40 to 14.41. It is noteworthy that at the Hospital in which the average stay was 14.41, a Recovery Branch has been established, and that the combined cost per occupied bed at this Hospital and its Home of Recovery is nearly £3 a year lower than at the parent Hospital itself.

In the fourteen provincial Hospitals with Medical Schools, the average length of stay of a patient varied during 1923 from 27.98 to 15.05 days. It is a fact that at the Hospital at which the stay was 15.05 days, a return was made of the total number of days of residence of seven long-stay patients. This total was equal to the time necessary for the treatment of 40 patients suffering from hernia or hemorrhoids. *The long-stay patients were retained because there was no accommodation available to which they could be sent, and for no other reason.* It is hardly possible to imagine a more uneconomic use of parent Hospital beds.

In Scotland, at the six large Hospitals with Medical Schools the average length of stay of a patient varied from 25 to 20.29 days.

The character of the work undertaken at these large Hospitals throughout the country and the scale upon which they are staffed and equipped, does not explain the variations in length of the patients' residence. Even if we assume that at those Hospitals in which the average stay approximates two weeks the staff and apparatus is already fully employed in the true economic sense, we cannot assume the same with regard to those at which the length of stay is a week or twelve days longer. Indeed, it is common knowledge that even at the busiest Hospitals a surgeon frequently retains a patient in his ward simply because there is no suitable accommodation to which he can be discharged, and not because to admit another patient in his place would be to throw too great a load upon himself or the staff of the Hospital.

The economic use of operating theatres, such as are provided at all large parent Hospitals, is limited by the number of beds available for patients operated on, and if any of these are occupied by those who could be transferred to a Recovery Branch, the theatre is not being used to its fullest possible extent, and so with all the other specialised buildings and departments. When the point has been reached, by means of Recovery Branches, at which the beds of a parent Hospital are being used to their fullest extent for the purpose for which they are best adapted, then it is time to develop and extend wards, operating theatres and other special departments. *It can never be an economic proposition to add beds to the parent Hospital and utilise them for the retention of patients a moment longer than is absolutely necessary.* And we are of opinion that this is the true test of whether, in any given locality, extension should be by way of Recovery Branches or by way of beds at the parent Hospital.

APPENDIX I.

The Average Length of Stay of a Patient.

We add a note on the figure "Average length of stay of a patient" as usually given in the Voluntary Hospital Reports.

In many Hospitals there is a two-months' book in which are recorded the names of those patients who require the special sanction of the Committee of Management for their retention longer than the authorised two months.

There is also a large number of patients who are admitted and retained an abnormally short period.

To include these two classes in the average, largely reduces the usefulness of the figure.

It is also a matter of considerable importance, especially at the present time, to know the extent to which the beds in each Hospital are being used for patients who stay in either an abnormally long or an abnormally short time.

It would give a more accurate picture of the work of the Hospital if there were a division on some such basis as the following:—

Number of patients resident under 48 hours.
Number of patients resident from 2 to 10 days.
Number of patients resident from 10 to 20 days.
Number of patients resident from 20 to 30 days.
Number of patients resident over 30 days.

It would, too, be an additional advantage to have separate figures for medical and surgical patients. The data for such a table is available in all Hospital registers and their extraction should present no difficulty.

The following illustrations are given *here* solely for the purpose of directing attention to a special point of some importance and not in criticism of the practice of any particular Hospital or the actual length of stay of patients, long or short.

1. A Hospital of 100 beds, in the Report of which the figures of stay have been given in detail:—

Average length of stay	...	...	22.07 days.	
535	patients	were resident	14 days or less.	
328	,,	,,	,,	15 to 28 days.
221	,,	,,	,,	29 to 60 days.
55	,,	,,	,,	61 to 90 days.
23	,,	,,	,,	91 to 180 days.
2	,,	,,	,,	over 180 days.
1,164				

Here it will be seen that only 328 out of a total of 1,164 stayed in for a period that did not vary from the average (22·07) more than a week longer or a week shorter, the remainder, 836, were in either a much longer or a much shorter period.

2. In the Reports of two of the largest Hospitals the following figures are given:—

	Average length of stay of medical patients.	Average length of stay of surgical patients.	Average.
A ...	12·70 days.	15·80 days.	14·41
B ...	39·8 ,,	15·6 ,,	21·5

Here it would not be concluded from the figures of the average of the totals that the medical patients in Hospital B were retained more than three times as long as the medical patients in Hospital A.

3. In a Provincial General Hospital of 150 beds, in which the average length of stay is given as 28 days, 24 patients had an average length of stay of 375 days. The inclusion of these patients, few in number, but occupying beds for an average period of over a year, largely discounts the value of the figure 28 days. Incidentally, these 24 patients occupied beds for a period long enough to have treated over 600 patients suffering from, say, hernia or hemorrhoids, etc.

4. At a Hospital of 100 beds with an average length of stay of 36 days, 46 patients were retained an average of 17 weeks.

5. In many of the small Hospitals the number of patients staying an abnormally short time (sometimes admitted and discharged the same day) form a very considerable portion of the total in-patients.

APPENDIX II.

NUMBER OF DAYS SPENT IN PARENT HOSPITAL BY PATIENTS IN FOUR HOSPITALS PRIOR TO ADMISSION TO HOMES OF RECOVERY DURING MONTHS DECEMBER, 1924, AND JANUARY AND FEBRUARY, 1925 :—

Hospital.	7 days and under.	7 to 14 days.	14 to 21 days.	Over 21 days.
A	14	30	21	35
B	2	28	28	36
C	—	32	30	52
D	2	4	13	31
Total ...	18	94	92	154

APPENDIX III.

TYPES OF CASES SENT FROM A PARENT HOSPITAL TO A HOME OF RECOVERY.

Out of a total number of cases transferred (402) from a Parent Hospital during the months December, 1924, and January and February, 1925, we have selected the following as typical :—

Pneumonia	33
Alimentary ulcers :—	
Gastric, Pyloric, Duodenal	24
Appendicitis	66
Heart conditions	16
Debility	7
Gastritis	7
Tubercular cases	15
Nephritis	9
Rheumatism	9
Gall bladder	8
Wounds and bruises	7
Fractures	9
Gynæcological cases	23
Ear, nose and throat cases	42
Eye cases	13

APPENDIX IV.

Cost of Drugs and Dressings.

London.

Hospital.	Average No. of days each patient was resident.	Amount in £ above or below the average, £17 : 11 : 2.
1	14·41	+ £2 6 6
2	16·90	− £3 17 2
3	18·48	− 8 8
4	18·60	+ £1 1 10
5	20·69	+ £8 11 11
6	21·47	− £3 11 10
7	21·50	− £3 5 0
8	22·46	− £1 10 5
9	23·22	− 12 5
10	23·47	+ 11 8
11	26·40	− £3 14 3

Provinces.

Hospital.	Average No. of days each patient was resident.	Amount in £ above or below the average, £24·3.
1	15·05	+ £11·0
2	16·10	− £4·5
3	17·30	+ £7·4
4	17·62	− £11·3
5	18·62	+ £4·0
6	19·20	+ £4·4
7	20·40	+ ·4
8	20·94	− £2·9
9	21·41	+ £5·2
10	23·52	+ £6·1
11	24·33	− £3·5
12	25·00	+ £4·0
13	27·77	− £5·9
14	27·98	+ ·5

Scotland.

Hospital.	Average No. of days each patient was resident.	Amount in £ above or below the average, £15·7.
1	20·29	+ ·2
2	20·70	+ £2·9
3	20·71	− £4·8
4	21·30	+ ·1
5	24·40	− ·3
6	25·00	− £2·3

PENSIONS FOR NURSES.

An explanation of the problem and a suggestion for its solution.*

BY

H. N. CROUCH,

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In February, 1925, there were 42,851 nurses on the Register of the General Nursing Council for England and Wales. Of these, it is estimated that 6,000 to 8,000 are employed in Voluntary Hospitals. The others are scattered over Great Britain, India, the Colonies, and the East, and are employed in Poor Law Infirmaries, Asylums, Statutory and other Hospitals maintained by County and Borough Councils, as District Nurses under Voluntary Associations, as Health Visitors, in Infant Welfare Clinics, in the Army, Navy, Air Force, and Prison Nursing Services, in private Hospitals, nursing homes and in private practice. There are, possibly, 20,000 nurses undergoing training, or trained but not certificated, in England and Wales.

It is contended, on behalf of the nurses, that the standard of physical endurance expected in a good nurse, is rarely retained without impairment by any woman after 50, that anyone, over 45, having no permanent post, has great difficulty in finding regular employment, and that only the exceptionally strong can continuously perform the full duties of a hospital or sick nurse after 55. Though specially competent women who take up private work may do well, the total wage earned by the average nurse, during her whole working life, leaves very little for investment after meeting necessary personal expenses and the cost of annual holidays. Since the middle of the 19th century there has been a steady effort to break with the old tradition that hospital nurses should be content with the pay and general conditions of a menial servant, and, as this tradition gives way to the new theory that they should be educated, refined gentlewomen, it becomes apparent that their normal pay is inadequate to make provision for old age suitable to their standard of living. It is argued that, as the social and intellectual qualifications demanded of nurses approximate to those of certificated teachers, their pay and retirement allowances should also be about the same.

Since 1914 there has been increasing difficulty in recruiting the right type of woman in sufficient numbers. A great many more nurses are required now than ten years ago; the reduction of working hours to the average maximum of 56 a week has meant larger staffs; the older Hospitals have increased their accommodation, and Cottage Hospitals have multiplied. Many new schemes, coming under the general term of "Welfare Work," require trained nurses. There are many more professions and callings open to women, some of which hold out big pay and rich prizes to the exceptionally competent. The woman who seeks only

* NOTE.—For most useful statistics and general information concerning Pensions for Hospital Officers and Staffs, readers are referred to the report of a Sub-Committee of the Executive Committee of King Edward's Hospital Fund for London. (C. & E. Layton, 56, Farringdon Street, E.C.4. Seven shillings and sixpence.)

independence, or satisfaction to the intellectual side of her nature, has a wide choice. There is a pronounced tendency for girls to select a career as soon as they leave school, and, though Cottage Hospitals accept girls at 17, probationers in the large Hospitals must be at least 19 years old.

To supply the deficiency, and to meet the competition of other forms of employment, Hospitals have raised salaries and greatly improved the general conditions of service. But there are still two main objections to hospital nursing—the disciplinary routine and restrictions on personal liberty, imposed on probationers and junior nurses, are irksome to the modern young woman, and apprehension as to the future, which haunts all single women of small means, is positively enhanced by becoming a nurse. The former objection is a domestic matter with which each Hospital must deal individually, but the latter can be met only by some general pension scheme; experienced opinion is strengthening that such a scheme must be devised if the nursing at our Voluntary Hospitals is to maintain its high prestige.

The practical difficulties in the way of successfully organising, and enforcing, an universal pension scheme, with immediate application to nurses in all forms of employment, seem insuperable. Though the College of Nursing represents 23,400 certificated nurses, there is no association representing all the nurses. The potential employers include the whole British public. There is a very great diversity of the conditions of employment and in the ability of employers to entertain a costly innovation. The Voluntary Hospitals have much in common; but each is absolutely independent of outside control, and it is only in a few of the large cities that there is even an attempt at co-ordination. The British Hospitals Association exists to watch the interests of the Voluntary Hospitals, but its Council has no authority to impose any policy.

The competence of Voluntary Hospitals to entertain any scheme which involves heavy extra expenditure is limited by the fact that their income is derived from charitable contributions, of which a large proportion comes from the working classes, and they cannot, without imperilling their income, yield to the demands which go beyond what the public sense of justice approves. Nor are they justified in giving extraordinary allowances to their nurses, or to any one else, on purely sentimental grounds. Further, Hospitals have many employees whose claim to a pension is, in many cases, quite as strong as that which can be made out for the nurses, and it would be difficult, and even unjust, to differentiate against them; but the total cost of providing pensions for all officers and servants would be more than the majority of Hospitals would be prepared to face. The position of District Nursing Associations is analogous to Voluntary Hospitals in that they are dependent on voluntary contributions, and experience equal difficulty in collecting funds.

Outside the scope of National Pensions Schemes, those only are considered to have even a moral claim to a pension who are picked men and women and give practically the whole of their life's work to the same employer. No employer recognises a short term of service as establishing any sort of right to a pension. But only a small percentage of those trained or obtaining employment in a Voluntary Hospital remain in it until retirement. Of a staff of 50 it is probable that 35 will be women training, who intend to seek employment elsewhere after winning their certificates, and seven will be staff nurses on the look out for posts as sisters. There is no form of occupation, except domestic service, in which labour is so liquid. The " lares and penates " of a nurse consist of a few pictures and ornaments; the housing difficulty does not exist, for quarters are always provided. They migrate from one Hospital to another, and from one part of the country to another, eager for change and fresh experience, and ambitious for promotion. A large proportion marry. There is no limit to the age at which a nurse or sister will resign her post, if promotion be offered.

An exception to the general rule, that no pension can be earned except by long and continuous service with the same employer, seems to be presented by the Federated Superannuation System for Universities, and by the schemes for teachers in State-aided schools and for officers in reformatories. But, in all these schemes, the ultimate employer is the State, and the Exchequer grant is subject to the condition that the immediate employer adopt a pension scheme. The State, in fact, pays the employer's contribution.

In the Nursing Services attached to the Army, Navy and Flying Forces, pensions form an essential part of the attractions offered. All nurses employed in Poor Law Infirmaries, Asylums, &c., have at least the opportunity of joining a contributory pension scheme. But in all the public services the members are carefully selected, mature women of more than average qualifications. The pension, so far as it is provided by the employer, can be earned only by long service; those guilty of misconduct, or proving incompetent, are liable to dismissal and to forfeiture of all pension rights; and the number of appointments is strictly limited. The pensions are, in fact, offered to attract the best type of women and to encourage continuous, satisfactory service.

Eight large London Hospitals, and one large provincial Hospital, have regular pension schemes for their nurses. But the schemes have application to the permanent staff only, and a minimum period of service—never less than ten years—is demanded. And, in every Hospital scheme which is not worked in co-operation with an Assurance Company, there is a careful proviso excluding all legal liability either to grant or to continue a pension.

In most large Voluntary Hospitals there is a virtual recognition of the moral right of a nurse who has given long and faithful service to receive a pension of some kind if she need it; there is no case known of a nurse who has given long service being compelled to retire without having enough to live on. But the aggregate amount paid by all Voluntary Hospitals in the Kingdom as pensions to retired nurses, sisters and matrons is very small, for it is only occasionally that the conditions are fulfilled which public sentiment has hitherto recognised as constituting a clear obligation to grant a pension.

" The Royal National Pension Fund for Nurses " was founded in 1887, to afford to nurses an absolutely safe means of providing, at the lowest possible cost to themselves, a certain income for their declining years. The Fund is incorporated under the Life Assurance Companies Acts, and is, technically, and in fact, an Assurance Association which confines its scope to nurses and to officials connected with Hospitals and kindred institutions. Its funds are enhanced by voluntary donations and subscriptions. Any nurse can withdraw her contributions at any time, with two and a half per cent. compound interest. On the 31st December, 1922, there were 13,581 policies in force, assuring annuities of £203,070, giving an average of nearly £15 a policy; but many nurses hold two or more policies. Seven London Hospitals and thirty-five Hospitals and associations outside London are affiliated to the Fund, and are prepared to pay the premiums on a second policy for any nurse who takes one out on her own behalf. As compared with ordinary commercial insurance companies, the Fund offers certain advantages and certain disadvantages.

The Nation's Fund for Nurses (registered under the War Charities Act, 1916) grants pensions and allowances to disabled nurses, and there are homes for nurses of small means who are no longer able to carry on their profession, maintained by " The Nurses' Memorial to King Edward VII."

In January, 1923, the College of Nursing, Ltd., issued a draft Superannuation Scheme of general application to all nurses in all forms of employment. Briefly, the scheme is that, in respect of every nurse, policies of insurance should be taken out from time to time, commencing with the second year of training, to secure such pension and alternative benefits

as can be assured by premiums representing fifteen per cent. of her salary, plus the annual value of her board and lodging, washing, &c. One-third of the premiums would be paid by the nurse, and two-thirds by the Hospital or other employer. The temporary patients of private nurses would be expected to pay nine shillings a week for the insurance alone. The amount of pension to which a nurse would be entitled to draw on retirement would vary with her period of service and the salary which she drew, or the income which she earned. A nurse who gained regular promotion in due course, up to the post of Matron, might be entitled to a pension of over £150. All benefits secured by the policy or policies would be regarded as deferred pay and be secured absolutely to the nurse herself, the employer from time to time having no right to a return of his contributions under any circumstances.

To the Voluntary Hospitals this scheme would mean an increase of the annual salary of every second year probationer and nurse, ranging from £6 13s. 4d. in the case of a second year probationer up to £40 in the case of a matron drawing £300 a year. Its essential weakness is that it flouts all known precedents in not offering to the employer the special advantages which attach to all known pension schemes—the limitation of employees to a carefully selected and absolutely efficient class, and long, continuous service with the same employer. The scheme makes on all employers of nurses novel demands which no public body, or commercial firm, or private individual, has ever considered it necessary or expedient to grant.

By the general adoption of this scheme, nursing would at once become the most attractive calling to every young woman between 17 and 21 who contemplated the possibility of marrying and desired to save as much as possible, at the expense of others, before doing so. There is no other occupation in which the employer invests a substantial sum every year for his apprentices and allows them to draw the accumulations, with compound interest, whenever they choose to throw up their job or prove themselves incompetent to pursue it. But there are nearly seven hundred Hospitals in England and Wales which recruit nurses, and, though no woman can be admitted on to the Register without undergoing a three years' training and passing a not very difficult examination, there is no standard of character or of physical and temperamental fitness to which all probationers and nurses must conform. Many Cottage Hospitals have to accept as probationers such girls as are willing to put up with the very poor conditions offered, and a woman may become a registered nurse though quite unsuited to stand continuous strain or to occupy a responsible post.

The scheme is complicated, and the chances of its acceptance prejudiced, by the necessity of taking out fresh policies on every increase of salary, no matter how small, and by making the amount of pension closely dependent on the annual value of the "emoluments." These provisions are necessary only if the aim be to make the amount of each pension bear an accurate proportion to the total annual value of the appointment held.

It is obvious that, in the attempt to formulate a pension scheme of universal application to all nurses, we are faced with a most complex problem and shall find ourselves compelled to recognise the "inevitability of gradualness." A beginning must be made with the nurses in the Voluntary Hospitals, and if any scheme is to gain, within reasonable time, the general acceptance of the hundreds of smaller and poorer Hospitals, it must be one that they can afford to join and will feel inclined to join. It must be obviously and indisputably reasonable, and, above all, it must be simple in its presentation and working.

It may confidently be asserted that, at the initial stage, Hospital committees will not, voluntarily, make extraordinary contributions to provide pensions for nurses other than those who have been selected for posts on their permanent staffs, and who intend to devote their lives to Voluntary Hospital work. They cannot reasonably be asked to include, in their pension schemes, young women who come to them for training only; there is no precedent

for doing so. Nurses coming within the scheme must be fully trained women who have declared their intention of permanently adopting Hospital work and have proved their competence by obtaining an appointment on the permanent staff of some Voluntary Hospital. Certificated women of 23 to 25 years of age can, ordinarily, obtain posts on the permanent staffs of small Hospitals, but many remain on at their training Hospitals to obtain further experience. It would be a graceful act on the part of the training Hospitals if they consented to include in their pension schemes all such women who purpose to adopt Hospital nursing as their life work.

But it is most desirable that young women should be encouraged to form habits of thrift, and for probationers and nurses in training a Saving Scheme is appropriate. There is no difficulty in formulating such a scheme (there are many in actual operation), and the contribution of any Hospital could be of such extent, and dependent on such conditions, as each determined.

For the permanent staffs of all Voluntary Hospitals it is suggested that the general aim should be to provide a pension of £100 a year, or thereabouts, at 55, for every nurse who, at 25 years or earlier, is appointed on to the permanent staff of any Voluntary Hospital and obtains promotion to Sister and Matron in the ordinary course of a successful career, and a proportionately smaller annuity for those who fail to obtain promotion in the ordinary course, or who are unable to continue working up to 55; that the scheme should be contributory and that the contribution of the Hospital should be similar to that of the nurse.

Schemes of this nature are now very common among County Councils, Municipalities, Banks, Insurance Companies and large commercial institutions, and all experience supports the theory that the prospect of a pension constitutes a powerful attraction to recruits of the desired type and most effectually encourages devoted service. Full value for the employer's contribution is returned in the shape of zealous efficiency and continuity of service. £50 a year, which is all the Hospital will contribute, as a special reward for the lifelong loyalty of an employee who rises to the highest post, is reasonable even according to the lowest commercial standards, and, in every case, the special reward by way of pension will be in exact proportion to the amount and quality of service given.

For the purpose of satisfying the usual condition that there must be continuity of service, the Voluntary Hospitals generally would be deemed to be a single unit, the whole charitable public being the ultimate common employer, and, as in the case of teachers and professors, the machinery for providing the pension would be that offered by the large assurance companies in the form of Endowment or Deferred Annuity Policies.

The advantage of adopting the machinery of insurance is that it contributes the element of portability to pension rights as they accrue. These rights are embodied in a policy, and a policy is merely a piece of paper which can be carried with personal baggage, or lodged permanently with an agent. No other system has been devised which enables the transfer from one pensionable post to another to be effected with so little trouble. Further, assurance companies, with their enormous accumulated funds, and highly skilled staffs, and special opportunities of favourable investment can offer a degree of security which, for practical purposes, can be regarded as "absolutely safe." No Hospital Committee, relying only on its own resources, could venture to impose on its successors a legal obligation to pay definite pensions in the distant future for an indefinite number of years.

The system of insurance, under what are termed Endowment or Deferred Annuity Policies, is easily explained. An assurance company, in effect, accepts money on deposit at compound interest, the usual rate being 3½ per cent. or thereabouts. At 55, or any other agreed age, the total amount standing to the credit of the insured person can be drawn in a lump sum

or be exchanged for a life annuity. 7.39 is the average rate per cent. allowed by way of life annuity for females at 55. It can be arranged that, in the event of death, or the insurance being terminated, the aggregate amount of contributions to date, with 2½ per cent. compound interest, can be drawn out, or a "paid up" policy issued. There is infinite variety of conditions under which any persons can insure by way of Endowment or Deferred Annuity policy; but, stripped of all technical mystery, the system of providing pensions by means of insurance is merely one by which a sum sufficient to purchase a life annuity, at a certain age, is gradually accumulated by annual payments placed on deposit at compound interest.

Though 3½ per cent. may seem a low rate, it is not less than a spinster, with unskilled advisers, ordinarily realises as the nett result of her whole savings in the course of her life. A large proportion of the distress among nurses can be traced either to their too unselfish generosity or to foolish investments. They need protection against the lure of speculative enterprises and the importunity of indigent relations; and taking out a policy effectively compels them to go on saving and to limit their investments to one thoroughly safe concern.

It is contended, by some, that the scheme of "mutual insurance" by the nurses themselves would yield a better return. Extraordinary benefits are obtained by many of those who contribute to some of the Indian Family Pension Funds, but this is due to the fact that all members of a certain service contribute to the fund but are entitled to benefit only in certain events. A mutual fund is, indeed, a scheme for mutual sacrifice; a large proportion of the contributors get no benefits at all. But nurses are not yet sufficiently intimately organised to make those sacrifices for each other which a mutual fund demands.

The special advantages which the National Pension Fund can at present offer depend on its endowment funds bearing a reasonable proportion to its total liabilities. Were the business to be greatly extended the advantages which it can offer over ordinary assurance companies would be diluted to a vanishing point. It is unlikely that the Fund would be willing to undertake the heavy responsibility attaching to a general scheme.

Nor is it advisable to entrust the management of the pension scheme to a voluntary association. Though the salaries of an expert staff would be saved, it is wholly improbable that better terms could be offered. For the highly paid expert more than earns his salary, and the overhead charges of the large companies are spread over so enormous a number of policies as to have only a negligible effect on the rate of interest which they can pay. And it would be difficult to form a voluntary association willing to undertake the responsibility of managing a large pension scheme. King Edward's Fund has definitely refused to do so.

If every nurse, on being appointed to the permanent staff of some Hospital, and being not more than 25 years of age, took out an Endowment or a Deferred Annuity policy for an amount requiring an annual premium of £6, a second policy at 30, with a premium of £5, and a third at 40, with a premium of £10, she would be able to assure for herself an annuity of approximately £50 a year at 55. And, if every Hospital agreed to contribute, by way of premiums on further policies, £6 for every nurse taken on to the permanent staff, £11 for each nurse of 30 years of age, and of not lower rank than a Ward Sister, and £21 for every nurse of 40 years of age, and also a Matron, or holding a post bearing a salary of not less than £100 a year, every nurse would have a reasonable chance of enjoying a total annuity of £100 a year at 55, even though she had periods of unemployment aggregating to a year or more.

The annual cost of such a scheme would not be alarming, for the numbers of the permanent staff represent, ordinarily, only one-third, or one-quarter, of the whole nursing staff. A Cottage Hospital, with a Matron and one Sister, would be asked to contribute £32 a year, or less, out of

a total expenditure of about £1,000. For a Hospital with 40 beds the cost would be about £76. To a Hospital with 50 nurses, and a total expenditure of £15,000 to £16,000, the scheme would work out at something under £190. It is assumed, in each case, that the present proportion of probationers and nurses in training would be constant. The cost would increase if a larger proportion of trained nurses were employed; and the tendency will be, probably, in this direction.

Most Hospitals would find it to their interest to adopt such a scheme, for there are few Managing Committees who have not in their employment either a Matron or Sister who, to their knowledge, has been unable to save anything substantial, and for whom they will feel bound, sooner or later, to make some provision. Even one pension might exceed the annual cost of a general scheme, and pensions seriously disorganise the normal budget of small institutions. The moral pressure on Hospitals to provide pensions, as a matter of course, will, almost certainly, become more pronounced year by year.

Every Hospital would be perfectly free to make the special contribution, or not, and no nurse would be under any compulsion to join the scheme. In order to attract and retain particular women, a Hospital could contribute more than the normal amount; it could, for instance, contribute £11 for a Ward Sister and £21 for the Matron, even though below the normal age; it could grant pensions, in special cases, on as generous a scale as it chose. But, were the larger Hospitals to generally adopt some reasonable and simple standard, the example would be followed, sooner or later, by the smaller ones; for no competent nurse who had joined the scheme would take employment at a Hospital where its benefits were not offered.

But public sentiment will insist on certain conditions. Donations and bequests to Voluntary Hospitals are prompted by compassion, humanity and religious duty. Nurses who get all they can out of a Hospital in the way of training and experience, and then join a public nursing service, or go abroad, or take up private practice, merely because the money rewards greatly exceed those offered by Voluntary Hospitals, do not come within the charitable intentions of testators and donors, and no nurse should enjoy the benefit of a pension contribution of the Hospitals unless she gives at least ten years to them after obtaining her certificate. Ten years is the minimum period usually recognised as establishing a claim to that special reward for long, continuous services which a pension constitutes. Any pension given as an extraordinary addition to the agreed salary is not merely " deferred pay "; a pension can be claimed as " deferred pay " only when it forms part of the wage contract.

Every nurse who elects to come under the scheme must herself take out and maintain a policy or policies for the standard amount.

Inasmuch as the main intention is to create a certain provision for old age, it should be a strict condition that no annuity accruing due as the result of Hospital contributions should ever be commuted. Whether or not the nurses should be allowed to commute annuities arising out of their own contributions is a matter for their own determination.

It is suggested that the benefit of all policies taken out by the Hospitals, which lapse for any reason, should go to a fund to assist Hospital nurses who break down prematurely. The recovery by each Hospital of its contributions might involve more trouble than it was worth, and most Hospitals would find it convenient to have a fund on which they would have a claim for those of their own nurses who fell by the wayside.

It will be necessary to constitute a central representative body to manage the scheme, to settle the panel of approved assurance companies, to act as trustees of the policies taken out by the Hospitals, to guarantee that the contributions of the Hospitals are devoted to their proper purpose, that the nurses maintain their policies and fulfil all conditions imposed

on them by the scheme, and to administer the fund for disabled members. Such central body would also be responsible for modifying the scheme to meet progressive requirements. Individual Hospitals would merely pay to the treasurer of such central body the annual premiums in respect of their insured nurses, and have no more concern with the matter. The duties undertaken by the central body would confer no right of interference with any Hospital in the engagement or dismissal of any nurse. The least suspicion of interference with their absolute independence would effectually deter the smaller provincial Hospitals from coming in.

Such a scheme as above roughly outlined would be intelligible by any committee, and workable by any honorary secretary. It should have a marked effect in biassing well educated young women and their parents towards the selection of nursing as a career and in improving the general standard of nursing. It would go far to satisfy the requirements of those who insist, on very strong grounds, that "something must be done for the nurses." There is nothing in it to arouse either resentment or jealousy; it is not open to the charge of being unduly generous, or of creating another "sheltered occupation." It offers no inducement to slackness or inefficiency; it helps them who help themselves, and goes no further in the direction of rewarding the work of a lifetime and assisting cases of premature breakdown than large industrial concerns find it expedient to offer in pursuance of their own material interests.

To those who would object that it does not go far enough and that the benefits offered are too small, the reply is that it aims merely at establishing some minimum standard which stands a reasonable chance of general acceptance, that it places no restrictions on the generosity of rich institutions, and permits of indefinite development. The general body of nurses will be far better served by a modest scheme which spreads rapidly through the country than by a more ambitious one which only a few of the larger Hospitals feel strong enough to entertain. It must not be forgotten that the money for paying the pensions has to come, spontaneously, from voluntary subscribers, the large majority of whom are quite poor people, and that it will come only in response to the quickening of their sense of humanity. To put forward demands for the nurses which exceed what the public will deem fair and reasonable is to do them a disservice.

Lastly, some reference must be made to the special case of District Nursing Associations. The ultimate common employer of district nurses is the same as that of Hospital nurses—the charitable public, and one of the earliest developments of the scheme would be the inclusion of district nurses within its benefits.

An article on Pensions for Nurses is not complete, at the date of publication of this Report, without some reference to the Widows', Orphans' and Old Age Contributory Pensions Act, 1925, which became law on the 7th August last, and comes into force on the 4th day of January, 1926. Under this Act, the weekly contribution, in case of nurses in Voluntary Hospitals, who are compulsorily insured under the National Health Insurance Act, 1924, will be increased from ninepence to one shilling and a penny. Of this, fourpence halfpenny will be the contribution under the new Act, which provides for Old Age Pensions at the age of 65, from the 2nd January, 1928. Of the total contribution, sevenpence will be payable by the employer. Provided the contributions are duly maintained, as required by the Act, up to the age of 65, a nurse will be entitled, at that age, until death, to a pension of ten shillings a week, irrespective of her yearly means. But, on ceasing to be employed, or on being promoted to a post carrying more than £250 a year, it will be necessary for her to become a "voluntary contributor," paying the whole contribution of one shilling and a penny a week (or eleven pence a week, where the contributor is disqualified from medical benefit, owing to her total means exceeding £250), up to the age of 65.

SUPPLIES TO MINISTRY OF PENSIONS HOSPITALS.

CO-OPERATIVE PURCHASING.

BY

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In the early days of the Ministry of Pensions, when only a few of its Hospitals were in existence, food supplies were purchased locally by each Institution. This proved to be an expensive and unsatisfactory system of supply. Medical Superintendents may not possess the business training or qualifications necessary to arrange successfully purchases on a large scale. In the circumstances they did the best they could, and relied mainly on the advice of subordinate officials in such matters.

In November, 1919, the number of Hospitals was increasing rapidly, and a central co-ordinating organisation was established to purchase collectively by central contracts (thus as first-hand buyers eliminating middleman's profits) and to arrange and control the supply of food to all Ministry Hospitals and Institutions. The beneficial results of this action were immediate and are specifically referred to in the Third Annual Report of the Minister of Pensions in the following terms:—

> "Hitherto each Institution had made its own purchases locally, the average daily cost per patient being 2s. 7½d. Under the collective purchasing system, this figure was reduced, and at the end of the year 1920 was only 2s. 1½d. a head, a saving of approximately £100,000 a year. The supply arrangements and the quality of the food were also much improved."

The number of Hospitals concerned was thirty-seven, with an average total feeding strength of 10,170 patients and staff. A year later the Hospitals had increased to sixty and the patients and staff to 17,600. These were the highest figures reached.

Certain articles of food must of necessity be purchased locally. These include milk, potatoes, vegetables, bread and mineral waters. A few weeks before the commencement of each quarter Medical Superintendents are instructed to invite tenders for these articles from all likely sources of supply. A short advertisement is inserted in a local paper and, in addition, the hospital officials are requested to explore personally all the available avenues of supply with a view to obtaining really competitive offers. The Medical Superintendent and his Quartermaster or Controller of Stores receive and open the tenders, and after consideration they are forwarded to Headquarters with their recommendations. In a number of instances these recommendations are acted upon, but frequently the prices quoted are considered by Headquarters to be too high, and the hospital officials are informed that the prices they have submitted are in excess of those obtained elsewhere and they are instructed to extend their enquiries. The knowledge at Headquarters of prices at other adjacent Hospitals often results in their being able to suggest the names of other contracting firms from whom lower quotations are obtained.

Other food supplies, including tea, coffee, cocoa, meat, fish, bacon, margarine, cheese, jam, sugar, eggs, canned goods and general groceries, are purchased by central and collective contracts

with manufacturers, importers and wholesalers. Uniform schedules of estimated quantities are received from each Hospital quarterly in advance. They are classified and summarised at Headquarters. When the total quantities are arrived at, tender forms are issued to approved firms who are invited to tender and submit samples of the articles they propose to supply. Tenders and samples are in due course received and the samples are analysed, tasted and examined. Values are compared and contracts ultimately placed. Each Hospital is supplied with a copy of all contracts that are made, and they requisition directly upon the various contractors for their supplies of tea, sugar, jam, cheese, &c., and the contractors deliver the goods required to the Hospital. Invoices in duplicate are furnished by the contractors to the Hospital with each consignment. One copy is retained at the Hospital for record purposes and the other, if correct, is accordingly certified and forwarded to the Accounts Branch at Headquarters for payment.

Certain food commodities such as eggs, vegetables, fruit, &c., which are subject to wide seasonal and other fluctuations in values, are not contracted for at fixed prices. Such a transaction would largely partake of the character of a gamble, and contracting firms are consequently advised to tender upon the basis of current wholesale market prices. In order that there may be no dispute as to what the ruling wholesale rates are from week to week, the prices recorded in the *Agricultural Market Report*, which is prepared by the Ministry of Agriculture and Fisheries, are agreed to. Competition is obtained by firms quoting a percentage discount off, or a percentage premium on, those rates.

The meat supply, which is the most expensive article of diet, is arranged by contract with shippers or by purchase at the Central Market, Smithfield, as required from day to day. A meat agent is employed to examine and take delivery of the meat from the Cold Stores or the Central Meat Market and defrost it in readiness for cooking. As in the case of other articles, Hospitals requisition directly upon the meat agents, who despatch the consignments required daily to the various Institutions. Not only does this system operate economically, but what is more important, the expert inspection of the meat agents results in a satisfactory standard of quality being maintained. The meat agents originally had defrosting and distributing centres at London and Liverpool, but in consequence of the closing down of a number of Hospitals, all the distribution is now effected from London.

Four scales of issue are in operation in Ministry Hospitals, namely:—

(1) Officer Patients and Medical Officers;
(2) Other Rank Patients;
(3) Nursing Staff;
(4) Subordinate Staff;

and each scale is fixed on the basis of the food required for 100 persons per day, a principle so strongly and justifiably advocated by the late Sir Napier Burnett, and not upon the old wasteful method of providing fixed quantities of food for each individual whether he wanted it or not.

Monthly returns are rendered to the Supply Section at Headquarters by each Hospital, showing the consumption of food by patients (see Specimen M.P.X.29) and staff respectively. These returns are examined, and the figures converted to the equivalent of 100 persons per day, so that the actual consumption may be readily compared with the authorised ration scales, and the observations of Medical Superintendents invited to any case of under or over feeding.

Summarised and classified food consumption returns are compiled monthly and circulated from Headquarters to each Hospital for comparative purposes. By this means, it is possible to maintain from Headquarters effective supervision over supplies of food to Hospitals and the issues.

A specimen copy of the food returns is appended. From the information afforded by these returns, the cost of feeding patients, nursing staff and subordinate staff separately is arrived at.

Cards are also written up for each Hospital (see M.P. Supplies 21 attached) recording month by month the food consumption for patients and staff respectively. At the end of twelve months fresh cards are opened.

The accompanying graphs clearly indicate the differences between obtaining supplies under collective purchase and local individual methods.

TRANSPORT.

Ministry Hospitals of 200 beds and over are supplied with an ambulance. Smaller Hospitals hire when necessary. Each Ministry vehicle carries a log book, in which details of all journeys are entered. The log book is divided up into sections as follows :—

1. Daily record of journeys.
2. Repairs, showing nature and extent of overhauls.
3. Tools and accessories, which are to be mustered and inspected every week.
4. Tyres and inner tubes, recording the life and mileage of each tyre and tube.

A return is furnished to Headquarters monthly, showing the operations of the ambulance in detail as follows :—

1. Number of journeys run.
2. The distance covered.
3. The quantity of petrol used.
4. The wages paid.
5. Depreciation.
6. Other costs (repairs, tyres, tubes, lubricants, &c.).
7. Mileage per gallon.
8. Cost per mile.

These returns are carefully scrutinised, and comparative returns are prepared and circularised each month to Medical Superintendents.

Supplies of petrol and lubricants are obtained from producing companies, but instead of Hospitals requisitioning directly upon the contractors, as in the case of food supplies, they intimate their requirements to Headquarters who issue a voucher to the Hospital on the contractor's agents at the nearest depot to the Hospital, and upon presentation the agent delivers the petrol and lubricating oil to the Hospital.

LAUNDRY SERVICES.

Laundry services are arranged by local contract, and the same method of issuing tenders is followed as in the case of those articles of food supplies purchased locally.

A common form of tender is used by all Hospitals, and the rates quoted are summarised at Headquarters for comparative purposes. If a Medical Superintendent has not at first been successful in obtaining tenders at fairly reasonable prices, the question may be referred back to him and he is then informed that other Hospitals not far away have obtained lower quotations. Names and addresses of firms to whom tenders may be sent are also suggested. This procedure usually results in lower prices being obtained.

Monthly returns are rendered by each Hospital, showing the number of articles washed each week and the number of patients concerned. From these, comparative returns are compiled and circulated to the Hospitals.

MINISTRY OF PENSIONS FORM M.P.X. 29.

Hospital M. **11,798 Days of Subsistence.**

RETURN OF PROVISIONS consumed by 446 patients during monthly period ending last Friday of each Month. 29th November to 26th December, 1924.

Article.	Quantity. Lbs.	Ozs.	Value. £	s.	d.
Beef	5,208	4	167	17	10½
Mutton	777	8	30	15	6¼
Lamb					
Veal					
Pork	171		8	14	6¾
Suet	86		2	15	6½
Chicken					
Rabbits					
Sausage, Beef	534		25	15	5¾
,, Pork					
,, Meat					
,, Luncheon ...					
Kidneys	63	8	2	14	2¾
Livers	180	8	5	16	7
Hearts					
Tongues					
Ox Tails					
Tripe					
Beef Extract					
Corned Beef					
Other Meats	249		5	16	3
Bacon	1,447	4	79	2	9¾
Fish (Fresh and Dried)	1,632	8	39	8	7¼
Fish (Tinned)					
Oxo		9		1	9¼
Total	10,350	1	368	19	2¾
Butter					
Margarine	1,089	8	23	12	7
Lard					
Total	1,089	8	23	12	7
Milk, Fresh ... pints	7,860	12	81	16	2
,, Tinned ... ,,					
Cream ... ounces					
Total	7,860	12	81	16	2
Eggs (No.)	3,964		49	17	9
Cheese	450	8	18	11	0½
Bread	9,620	12	73		3¼
Flour	1,204		10	1	6¾
Biscuits	42	4	2	1	4½
Total	10,867		85	3	2½
Tea	293		29	6	0
Coffee	3	9		5	4
Cocoa	73	8½	1	7	6¾
Total	370	1½	30	18	10¾
Sugar	1,458		23	5	9
Jam	287		6	5	6¾
Marmalade	364		6	8	11
Golden Syrup	28			7	8¼
Honey					
Total	679		13	2	2

Article.	Quantity. Lbs.	Ozs.	Value. £	s.	d.
Rice	121		1	2	8¼
Sago	127	4	1	15	5¾
Tapioca	134		2	6	0¾
Macaroni					
Cornflower	6			1	2½
Arrowroot					
Oatmeal	487		4	9	1½
Rolled Oats					
Barley	12			2	3
Ground Rice					
Semolina					
Haricot Beans ...	82			9	8½
Butter Beans					
Split Peas	12			1	9¼
Dried Peas					
Lentils	38			6	7¼
Other Cereals	57			15	0
Total	1,076	4	11	9	10¾
Potatoes	8,081	12	43	1	10
Vegetables	4,360	4	11	15	3
Other Vegetables and Fruit (fresh and dried)	1,293	14	27	15	2¾
Total	13,735	14	82	12	3¾
Brandy ... ounces					
Port					
Total					
Sundries (in detail) :—					
Sauces ... 214 bottles			3	11	4
Pickles 33 galls.			4	10	9
Pepper	13			6	2¾
Salt	356			19	10¼
Mustard	21	8	1	10	
Herbs ... 14 pkts.					8¾
Vinegar 58 pints				10	10½
Jelly Squares 118 pkts.			1	10	8¾
Gravy Colouring 23 bots.			1	1	1
Egg Powder	4			1	5
Baking Powder ...	4	5		1	6
Custard Powder ...	133	8	2	4	6
Soda Bicarb.	14	8		2	5½
Nutmegs		3			3½
Cloves		4			4¼
Cream of Tartar ...	3	8		3	0¾
Total			16	15	2

Ministry of Pensions Form M.P. Supplies 21.

PATIENTS.

Hospital M.	Cost	Meat.				Bread	Veg'ts	Marg.	Sugar	Milk	Eggs	Tea	Jam	Cereals	Cheese	M.L.	W.S.	Cal's.
		Meat	Fish	Bacon	Total													
	s. d.																	
Jan. 1924.	1/3.02	54	16	14	84	108	116	6	9	59	37	3	10	12	4	—	—	3,733
Feb. ,,	1/2.70	59	14	12	85	116	122	6	9	62	39	3	10	11	4	—	—	3,870
March ,,	1/2.25	48	19	12	79	118	121	6	9	60	42	3	9	12	4	—	—	3,680
April ,,	1/2.17	47	22	11	80	115	121	6	9	67	34	3	9	12	3	—	—	3,775
May ,,	1/1.60	50	16	12	78	109	107	6	9	62	42	3	9	13	4	—	.2	3,659
June ,,	1/2.15	51	18	12	81	100	113	8	11	61	42	3	7	12	4	—	—	3,672
July ,,	1/2.38	59	13	12	82	93	104	9	12	64	49	3	6	11	5	—	—	3,633
Aug. ,,	1/2.82	61	12	12	85	94	106	9	12	70	48	3	6	13	5	—	—	3,745
Sep. ,,	1/3.40	62	12	12	86	101	122	9	12	70	38	3	6	10	4	—	—	3,813
Oct. ,,	1/4.01	65	13	12	90	102	119	9	12	70	42	3	6	9	4	—	—	3,851
Nov. ,,	1/4.19	62	13	13	88	103	119	9	12	69	36	3	6	9	4	—	—	3,831
Dec. ,,	1/4.40	62	14	12	88	91	116	9	12	67	34	3	6	9	4	—	—	3,633

For information and comparison.

CENTRALISED HOSPITALS.

Comparative Statement showing Consumption of Food in Ministry of Pensions Institutions during period 29th November, 1924, to 26th December, 1924, on the basis of 100 persons per day.

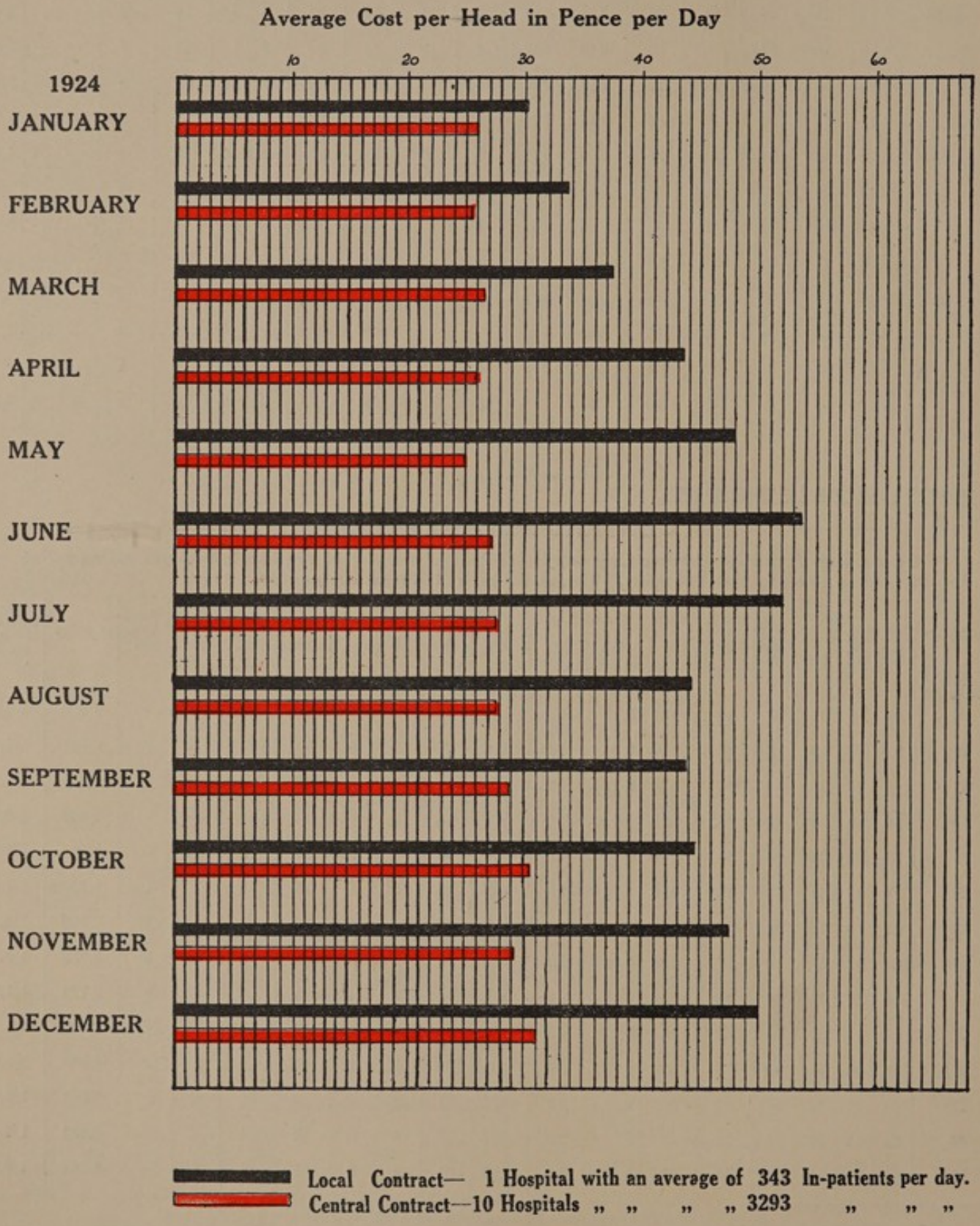
Institutions.	Meat.				Bread.	Vegt.	Marg.	Sugar.	Milk.	Eggs.	Tea.	Jam.	Cereals.	Cheese.	Malt Lqrs. pts.	Wines, Spts. ozs.	Calories.	Cost of subsistence per head per day.
	M. lbs.	F. lbs.	B. lbs.	Total lbs.	lbs.	lbs.	lbs.	lbs.	pts.	No.	lbs.	lbs.	lbs.	lbs.				
(For "other Ranks.")																		s. d.
A	61	16	15	92	92	164	8	12	146	59	3	9	16	8	—	—	4,396	1/10.16
B	52	22	14	88	80	110	6	12	123	66	3	8	16	4	—	7	3,711	1/7.27
C	44	18	14	76	102	131	8-1 oz.	12	76	44	3	7	10	6	—	—	3,871	1/3.46
D*	56	5	9	70	54	113	6-3 oz.	10	70	41	3	8	10	3	—	—	2,906	1/3.23
E	58	22	14	94	81	116	9-2 oz.	12	85	49	3	5	18	5	—	—	3,866	1/5.18
F	51	19	11	81	83	106	9	13	120	55	3	6	16	3	—	1	3,788	1/5.65
G	63	8	12	83	103	131	9	11	80	47	3	6	13	4	—	.6	3,902	1/4.89
H	60	17	11	88	77	126	9	13	109	66	2	6	9	4	—	5	3,738	1/5.97
I	56	19	11	86	83	114	8	12	110	56	3	6	14	4	—	9	3,772	1/7.88
J	58	11	15	84	82	128	6	12	84	35	3	9	12	4	—	.4	3,704	1/4.12
K†	48	30	17	95	76	126	8	12	134	80	5	5	17	5	3	15	4,026	1/9.66
L*	64	11	15	90	60	123	8	13	79	51	3	6	9	3	2	1	3,381	1/6.68
M	62	14	12	88	91	116	9	12	67	34	3	6	9	4	—	—	3,633	1/4.40
N	60	21	13	94	68	116	8	12	123	84	4	4	8	4	2	20	3,757	1/8.99

Authorised scale 3,780 calories per head per day.

* Includes Staff.

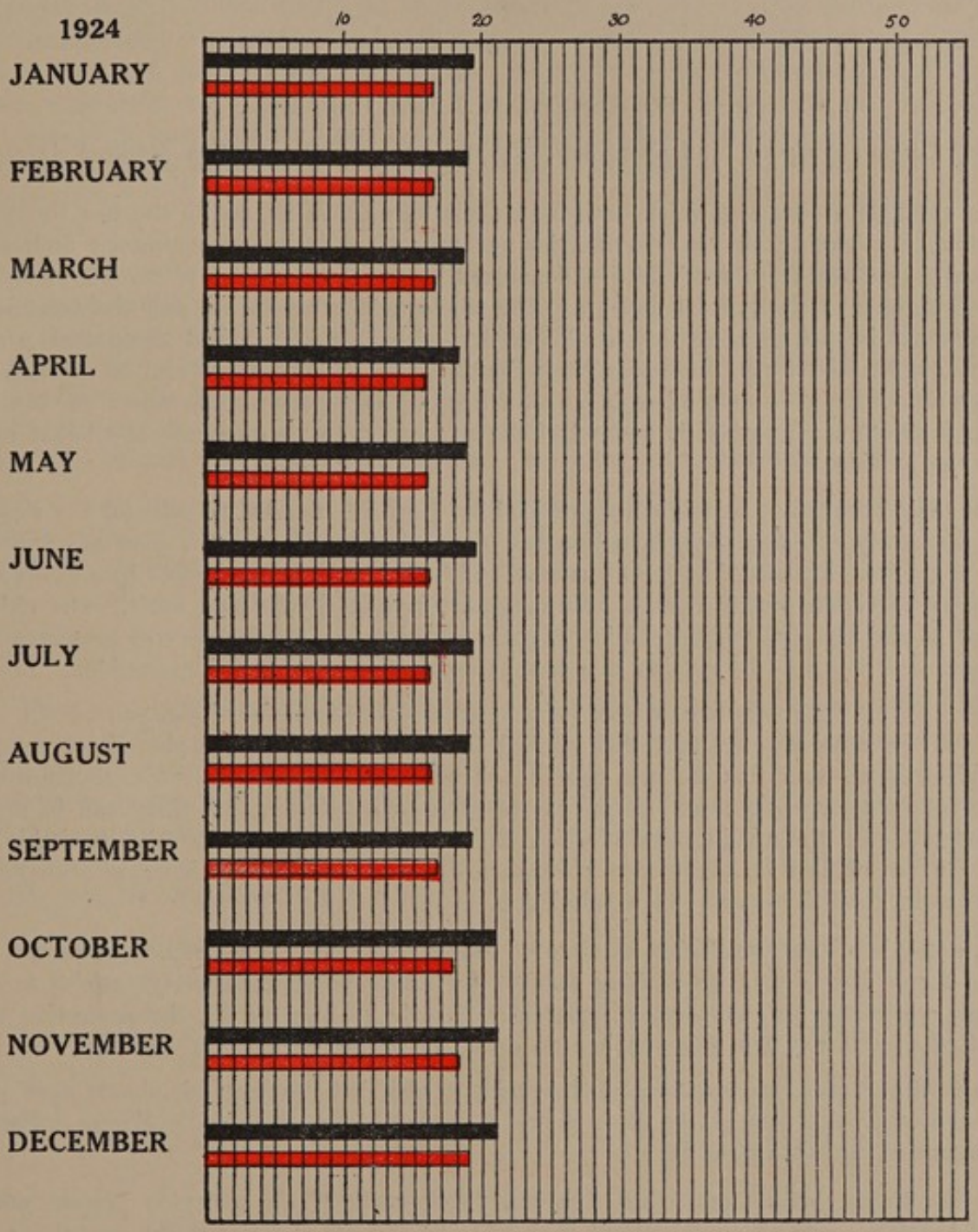
† Includes special diets for Diabetics.

COST OF FOOD SUPPLIED IN MINISTRY OF PENSIONS HOSPITALS FOR OFFICERS.



COST OF FOOD SUPPLIED IN MINISTRY OF PENSIONS HOSPITALS FOR OTHER RANKS.

Average Cost per Head in Pence per Day.



Local Contract— 6 Hospitals with an average of 720 In-patients per day.
Central Contract—30 „ „ „ „ „ 7400 „ „ „

HOSPITAL ACCOMMODATION FOR THE MIDDLE CLASSES.

BY

H. S. SOUTTAR, C.B.E., F.R.C.S., Etc.,

Surgeon, London Hospital, and Chairman, Hospitals Committee, British Medical Association.

The prodigious advances which have been made by medical science in the last thirty years have brought in their train two results, the necessity for a technical equipment undreamt of before that time, and for a specialisation demanded by the mere volume of our knowledge. No human being can at the present day grasp the whole field of medicine, and the most learned of men would be powerless to use his knowledge without the technical equipment which is essential for its application. In our hospitals the technical equipment is found on a lavish scale, and each of our great hospitals has in its staff a group of specialists, by whose combined and co-ordinate efforts each patient is assured of the application to his own case of all that medical science can provide.

But these hospitals were originally provided by charitably-minded persons for the sick poor, and consequently the anomalous situation has now arisen, that only the poor are entitled to the use of equipment provided at enormous cost, and that they alone can benefit by a co-ordination of specialist service to which there is no counterpart outside the hospital walls. The rich man can perhaps obtain a makeshift imitation at great expense, but for the man of moderate means such treatment as comes by routine to a hospital patient is absolutely inaccessible.

It is only in an institution of some size that a surgeon, for example, can obtain all the expert assistance he may require, that clinical laboratories and radiographic departments can be at his disposal and that he can call in colleagues for advice without a thought of the expense involved for his patient. It is only in such an institution that there can be provided at a moderate cost, the nursing service which is the basis of all his work. The inevitable result is that we are obliged to admit to our hospitals in large numbers patients who on financial grounds alone could have no right to admission.

Now this is a most unsatisfactory state of affairs. The real poor have to be turned away, and the doctor has to give for nothing services for which he is most justly entitled to expect payment, whilst the patient himself, gratefully though he may accept the protection of the hospital, wishes to pay his way and has no desire to be the recipient of charity.

There are at least two solutions of the problem, one that the hospitals should open paying wards, the other that special hospitals should be provided for the middle classes. Each has advantages and each has difficulties.

Paying wards would seem to be a natural development of the policy at present practised in most hospitals, whereby each patient pays what he can afford towards the cost of his maintenance and treatment. To the hospital they present great advantages, for it can now claim that its doors are open to all who need its services; without any drain on the charitable funds of the hospital, such wards expand the usefulness of its work; they give opportunities for the nursing staff and residents to become familiar with the peculiar requirements of private work; and they spread a knowledge of hospitals, and an interest in their work, through another class than that to which their services have hitherto been limited.

To the medical staff such an arrangement is also advantageous, for besides providing accommodation for a difficult class of patient, it enables them to concentrate the bulk of their work under one roof and to carry it out under uniform conditions, enormously improving its organisation and effectiveness. An objection has in some quarters been raised to the limitation of treatment in such wards to the visiting staff of the hospital, but it is a little difficult to see on what grounds it can be claimed that the ability of a patient to pay, alters the qualifications and standing required in his medical attendant.

A special hospital requires the outlay of a large capital sum, and the scope of the hospital must largely depend on the conditions under which this is provided. If for instance this is on a business footing and interest has to be paid, it is obvious that the charges must be higher than if it were the gift of a generous donor. When we consider that at some of the great hospitals, with their vast endowments and free medical service, the cost per patient is close on £5 per week, it is fairly obvious that for a large section of the middle class, hospital provision on a purely business basis is impossible. Either generous donors or the State must assist in the capital outlay, and even then it can only be made to pay if wealthier patients are admitted at higher rates.

As admirable examples of the two methods, we may mention the new private wing at the West London Hospital, and the new Private Hospital at Leicester. At the West London Hospital, as the generous gift of Mr. Mason, a special wing has been built and fitted with single and double rooms, for which the charges are respectively five and four guineas a week. There is an income limit, the fees payable to the medical staff are assessed by a special committee, and all payments are made through the Secretary of the Hospital. The system has been an unqualified success, the beds are always full, and there is now actually a waiting list.

At Leicester, the splendid generosity of Mr. Fielding Johnson has provided that city with a private hospital of 50 beds, lavishly equipped with every modern convenience. It is at the service of the whole medical profession in Leicester for medical, surgical and maternity cases. The minimum charge is five guineas a week, and medical fees are entirely a matter to be arranged between the doctor and his patient. The hospital is not run for profit, but must pay its way.

In these two examples of enterprise and generosity we have an opportunity of testing the merits of two solutions of one of the most important problems of the present day. All hospitals are not so well placed as the West London for its experiment, and not many cities are likely to be so fortunate as Leicester. But the urgency of the problem increases every day, with every new advance in medical art. We must not rest content until all our resources are available, not only for the very rich and the very poor, but for that great hardworking Middle Class who form the backbone of our nation.

HOSPITALS, GENERAL AND SPECIAL.

BY

N. BISHOP HARMAN, M.A., M.B.Cantab., F.R.C.S.Eng.,

Senior Ophthalmic Surgeon to the West London Hospital, &c.

THE QUESTION AT ISSUE.

The part that should be played by General and Special Hospitals in a comprehensive hospital organisation is a matter of growing interest. It is of interest whether the problem be viewed from the national or local standpoint. Hospital organisers must necessarily view the problem as it applies to the area of their work, but these same workers should on occasion take the larger view of national requirements, and envisage the problem as it appears to those whose duty it is to strive to adjust the demands of area and area. Few areas can or do stand alone. Modern facilities for intercommunication have laid flat the boundaries of formerly self-contained areas, so that there can be found but few which can now claim that they are independent of the greater whole.

It is well at the outset to define our terms, and to do so in relation to present-day practice. Whatever the connotation of the terms may have been in the past, we now use the words "General" and "Special" in a strictly regular manner. We mean by a General Hospital one that admits to its services all kinds, or almost all kinds, of disease in any age or sex; and we mean by a Special Hospital one that restricts its services to one type of disease or one type of patient as defined by age or sex.

The question at issue is the relative advantage or disadvantage of such General or Special Hospitals.

ORIGIN OF HOSPITAL TYPES.

It is of interest to look back upon the origin of these types of Hospitals. The earliest Hospitals were almost entirely General Hospitals. They admitted to their services patients suffering from any kind of disease that needed treatment. Special Hospitals are for the most part of modern origin. In the early decades of the nineteenth century, concurrent with the rapid increase of industry in this country and the growth of large urban populations, there was an equally rapid development of medical science. There was an increasing knowledge of and ability to treat general diseases, and also an immense development in the recognition of and skill in the treatment of disease of special regions of the body. The advance was so rapid that large additional clinical facilities were needed. In this country, where the enthusiasm and energy of volunteer works have always blazed the path of progress and brought new fields of work into cultivation, the process of development of hospital service followed what is to us the natural mode. For instance, keen workers in the field of eye diseases started clinics, or dispensaries as most of them were first called, for the treatment of these diseases. One or two doctors in association established in a small way in some convenient house an institution which later has become a recognised Eye Hospital. This is the story of most of our best known Ophthalmic Hospitals, *e.g.*, Moorfields in London; the Hospitals in Edinburgh, Glasgow, Oxford and Maidstone, to cite only a few.

It would appear that there was no idea in the minds of these early founders of Special Hospitals of separation or isolation from or competition with General Hospitals. There was a need, so they proceeded to meet it in the simplest way. To expand an existing institution was or might be difficult. To set up something new was easy, and the new made a ready appeal to philanthropists. This method of working accounts for conditions that seem to us to-day extraordinarily anomalous. There is at Charing Cross in London a large General Hospital with its own eye department and next door to it there is an Eye Hospital; the walls of the two buildings are conterminous. There is in Maidstone at one end of a short street a General Hospital, and at the other end a Hospital for the disease of the eye, nose and ear. These seemingly anomalous conditions are explained by the natural idea of the founders of the later Special Hospitals, to provide for new wants, as near as might be to the older foundations, which formed as it were a focus of medical work in their own and the public eye.

In later days there was indeed some spirit of rivalry in the formation of further Special Hospitals. General Hospitals recognised the necessity for special departments in their own organisation, and these with the increasing number of new Special Hospitals engendered a competition for patients which was not altogether healthy in that it led to abuse of hospital facilities. Those conditions are less evident now. New Hospitals are not easy to form, the tendency is to improve and expand existing institutions, but there is still some sign of excessive specialisation, especially, under the pressure of social reformers, in the provision of special clinics under statutory authority, *e.g.*, Tuberculosis Dispensaries, &c.

THE ACID TEST OF EFFICIENCY.

The determination of the relative value of Special and General Hospitals must be based upon their working efficiency in regard to the patient. Which type of Hospital is best for the patient, whatever be the nature of his ailment; and which in the long run fosters the best type of medical practitioner, that is to say, the practitioner most able to cope with the disability of the patient?

My answer to these questions may be given now, so that there may be no doubt in the mind of the reader as to the trend of the argument. In my judgment there can be no doubt that the General Hospital is better than the Special Hospital, better for the patient, and better in that it cultivates a superior type of medical work.

The human body must always be considered as a whole if the medical practitioner is to minister successfully to its needs. The members of the body cannot and must not be considered as detached units. Modern medicine reaffirms and proves the Pauline dictum " all the members of the body, being many, are one body." A defective eye may react upon the whole body or the defect of the eye may be a reaction brought about by a general bodily ailment. And so it is with disease of any other of our special organs. To limit the diagnosis to the " eye," the " nose," or whatever may be the organ under examination, is to limit the power of curative medicine and the prospects of the patient. Work in a Special Hospital tends to be limited, bounded as it were by a ring fence. It is a natural effect of a limiting name. That this tendency is being resisted there is ample evidence, and some of this evidence will be noted later. On the other hand, in a General Hospital there is a constant recognition of the full field of medical work. There is daily contact between the general physician and surgeon, the eye surgeon, the gynæcologist, the dental surgeon and so forth. Each of these gives to the other a daily hint of his field of work, and with that there is an unconscious widening of outlook for each member of the staff, so that no matter to what department a patient may be drafted after the preliminary examination, the chief of that department is always conscious of the whole anatomy of his patient. The physician or surgeon of a department recognises that he is one of a team, every member of which is at his service in elucidating the primary

origin of the disease under investigation, and through such combination there is laid the foundation of ever widening extensions of preventive medicine.

RECENT TENDENCIES.

The advantage of the General Hospital plan of work is demonstrated by recent developments of Special Hospitals. It is rare now to find in a Special Hospital the members of the staff limited to practitioners of that speciality. On the staff of an Eye Hospital there will be found neurologists, aurists, and even dental surgeons. On the staff of a Nerve Hospital there will be found eye surgeons, aurists, gynæcologists, orthopædic surgeons and so forth. On the staff of a Lying-in Hospital will be found physicians and surgeons, a physician for antenatal work, another for infant consultations, and also ophthalmic and dental surgeons. Such a range of staffing in Special Hospitals is proof of the desire for a wide outlook and comprehensive team work, in fact it is an attempt to make the work of the Special Hospital as near akin to that of a special department in a General Hospital as is possible. Again, in recent years there have been amalgamations and close associations formed between General and Special Hospitals whereby the Special Hospital has become an integral part or department of the greater General Hospital.

It may be asked: Is there no countervailing advantage in the Special Hospital, *e.g.*, in the intensive cultivation of one branch of work in one place? There is such an advantage. Doctors are as gregarious as other human workers. It is of interest to us to work together, especially when we are doing the same work. Minds are stimulated, ideas are kindled, and on occasions special advances are secured. But there is a risk of one-sided growth through loss of contact with general medicine and surgery or of loss from failure to know what other branches of medicine are doing. Special Hospitals are not the sole means whereby we specialists intercommunicate. We have our special medical societies, our sections in the greater medical societies, and our clinical meetings in Hospitals.

THE RULE AND EXCEPTIONS.

My conclusion is that a General Hospital with a range of departments covering all modern requirements is the ideal unit of hospital organisation. It provides the maximum of benefit with the minimum of risk. But that does not mean that Special Hospitals should cease to exist. In a great city Special Hospitals may be of convenience in dealing with large numbers of patients of a presumably distinctive type, also for concentrating special research and teaching in universities. There may be limitation in the ground space available for a central General Hospital, so that outlying clinics attached to the central Hospital may be more economical, and if these are annexes of the central organism the disadvantages of excessive specialisation are reduced. Again, certain kinds of disease need long periods of treatment, and treatment in the country rather than in the towns, *e.g.*, orthopædic cases and tuberculosis. Other disease might present danger or inconvenience in the General Hospitals, *e.g.*, specific fevers and mental disease. Safety and convenience makes for separate accommodation in these cases. But there is no physician who will not agree that so far as fevers are concerned separation is a matter of convenience only and not an ideal medical arrangement. Whilst in the case of mental diseases the evidence given before the Royal Commission now sitting is conclusive that the ideal for mental cases is treatment in association with General Hospitals. Something more than convenience justifies Children's Hospitals, they are in fact General Hospitals for children, their smaller size makes them better units for the little ones; but even with these Hospitals there are occasional difficulties in dealing with the older children, and in finance because of the relatively high cost of laboratory and physical equipments in small Hospitals, both these difficulties make an association with the larger General Hospital desirable. The treatment of disease of the nervous system and of orthopædic cases is commonly of such long duration and requires such complicated and special equipment that there is a

real justification for separate provision. But there is no such justification for separate Hospitals for disease of the eye, nose, ear, throat, skin, heart, rectum, urinary organs, for cancer cases, nor for radiological treatment. All these are better provided for in, or at least in association with the unit of hospital organisation, the General Hospital.

BRITISH AND AMERICAN OPINION.

So far as my information goes this is the trend of opinion within the British medical profession both amongst men in general and in consulting practice. It is also the expressed opinion of the most recent writers on American Hospitals, where the English system of voluntary initiative is dominant. Corwin* in a survey of the hospital situation in Greater New York writes: "The fact that so large a percentage of hospital beds in the City is to be found in the Special Hospitals (about 37 per cent.) raises the question of the desirability of such development." He concludes, "It is safe to say that in the City of New York in the development of special institutions the zenith has been reached, and that hospital development in the future will probably proceed along lines of greater scope on the part of General Hospitals."

STATESMANSHIP.

The situation in this country calls for the direction of wise statesmanship. The British Medical Association† after consideration of this matter has urged that the Local Voluntary Committees, now existing, should be expanded so as to enable them to survey all the hospital accommodation of their areas, to determine the adequacy of this accommodation, to foster co-ordination between existing Special and General Voluntary Hospitals and municipal and poor law institutions for the treatment of the sick; and to do so without interfering with the domestic autonomy of the several Hospitals, each being encouraged to work upon those lines of local initiative which have proved so vital in local work. Further, that the duties of the Voluntary Hospitals Commission should be extended so as to make it a Standing Consultative Hospitals Committee for England and Wales, representative of all the Local Voluntary Hospitals Committees, and to act as between the Ministry of Health and the Local Committees in all matters concerning the hospital policy of the Ministry.

The time is ripe for a move in this direction, and it is better that such a move should come from within the Hospitals rather than from without.

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* The Hospital Situation in Greater New York. Report of or Survey of Hospitals in New York City by the Public Health Committee of the New York Academy of Medicine, prepared by E. H. Lewiniski-Corwin, Ph.D., New York and London. G. P. Putnam's Sons, 1924.

† Policy affecting Hospitals. Section A. on Inter-relation and Co-ordination of Hospital Provision. British Medical Association, London, W.C.1, 1925.

ELECTRIC COOKING IN HOSPITALS

in special reference to

HEATHERWOOD HOSPITAL, UNITED SERVICES FUND, ASCOT.

BY

J. G. JOHNSTONE, M.B., O.B.E.,

Medical Superintendent, Heatherwood Hospital, Ascot.

The problem of Hospital cooking methods is one of considerable interest and importance due to the questions of capital cost, maintenance, staff, and lastly the results obtained from their use. The employment of electrical apparatus for cooking purposes in this country has been very limited for a variety of reasons. The vast majority of Hospitals in this country have been built many years ago before electricity was known or its uses recognised or established. They, therefore, already possess another form of plant for cooking purposes. The newer Hospitals have not installed electric cooking appliances because either the unit cost of electricity in the district was high, or the efficiency of the appliances on the market had not been proved. This has all militated against its abundant use in the past. However, at the present day the recent advances have proved that this type of cooking can be undertaken with a surety that it is reliable, efficient, and economical. It must also be clearly understood that at the present time no Hospital kitchen can be satisfactorily equipped with only electrical apparatus, but that it should have also a supplementary equipment of steam appliances.

Heatherwood Hospital (136 beds) was opened in April, 1922, for children suffering from Surgical Tuberculosis and other forms of crippledom. The Hospital did not receive its full complement of patients until June, 1923, so that the kitchen appliances were not working at their full capacity until after this latter period, a point which should be borne in mind in connection with the renewal and repair figures quoted later.

The kitchen is equipped with steam and electrical appliances. The steam and electricity are made in the power house. The Hospital kitchen has to cater for 136 patients (up to 14 years) and 67 female staff, making a total of 203 persons. Twenty-three sets of meals have to be cooked throughout every day, served in relays, for some of which steam and electricity (14 relays) are used, for others steam only (9 meals) as shown below.

	Patients.		Staff.	
Meal.	Method employed.	No. of Relays.	Method employed.	No. of Relays.
Lunch	Steam only	1	Steam only	2
Supper	,,	1	–	–
Tea	,,	1	Steam only	4

When cakes are cooked for tea the *electric* ovens have to be used.

	Patients.		Staff.	
Meal.	Method employed.	No. of Relays.	Method employed.	No. of Relays.
Breakfast	Steam and Electricity	1	Steam and Electricity	4
Dinner	,,	1	,,	4
Supper	–	–	,,	4

The Hospital kitchen is equipped with the following:—

Electrical Cooking Appliances (Capital Cost).

		£	s.	d.
1.	Four ovens arranged in pairs loaded to 8 kw. each	266	0	0
2.	One compartment grill loaded to 5 kw., that is 2.5 kw. each side	100	0	0
3.	One fish fryer loaded to 5 kw.	22	6	6
4.	One boiling plate loaded to 800 watts		14	0
5.	One small electric range with oven and hot plate	34	0	0
		£423	0	6
6.	One motor-driven Hobart machine, .3 h.p. motor	284	0	0
7.	One motor-driven potato peeler, .3 h.p. motor	40	0	0
	Total	£747	0	6

The two last electrical appliances are used only in the preparation of food for consumption, and have been included because the electrical consumption is included in the subsequent annual amount quoted.

Steam Cooking Appliances.

1. One three-compartment steam oven.
2. One bain-marie.
3. Three boiling pans.
4. One jam boiler.
5. One water boiling urn.
6. Two carving tables and hot cupboards.
7. One boiling tank with jet.

The four electric ovens are used for all baking purposes. The electric grill is employed for toasting and grilling. It is of sufficient capacity to cook for 12 persons at one time. The boiling plate is used for boiling up small quantities of water.

In order that the night nursing staff should not use the main kitchen the electric range is accommodated in a scullery adjoining their night quarters, and is mainly used in heating their two meals during the night, their other meals being cooked in the main kitchen. This electric oven is run from the kitchen block lighting system and its electric demand is not contained in my later figures of the number of units used in the main kitchen, but this amount is so small as not to make any appreciable difference.

The Hobart machine is one in more general use throughout the country, and may be employed for a multitude of purposes, such as making dough, straining soup, potato mashing, sausage making, mincing meat, &c. The potato peeler is, as its name implies, for rapidly peeling potatoes by means of its revolving carborundum disc combined with a water supply for washing potatoes and drawing off the coat which has been removed.

All these appliances have been found to be most satisfactory in relation to cleanliness and efficiency, economy in running and in renewals and repairs. Although a variety of apparatus has been shown above, the general efficiency of the kitchen would be greatly enhanced by the installation of surface heat, as steam has to be used for that purpose, which is not economical. Some experience has to be gained in the use of these appliances in gauging the heat and length of time required to cook meat. The ovens are fitted with switches indicating high, medium and low degrees of heat. The cooking is all plain in character, being that common to most institutions. The staff required to cook the food and clean the kitchen is four, consisting of a head cook, one assistant cook, and two kitchen maids, working under the supervision of a housekeeping sister.

I consider that the type of kitchen is of importance. The kitchen at Heatherwood has a very lofty ceiling, so that the temperature in the height of summer is comparatively low, making for very great comfort to the staff. It is most noticeable that even on the hottest day in the summer time the kitchen is comparatively cool, and as there are no gas appliances the absence of nauseating gases is most noticeable.

The following is the cost of renewals and repairs to these electric appliances from the opening of the Institution until December, 1924, a period of 33 months :—

Apparatus.	Renewals and Repairs.	£	s.	d.	£	s.	d.
1. Ovens	Indicator lamp and fuses		14	0			
	New switch		10	0			
		£1	4	0	1	4	0
2. Grill	Indicator lamp and fuses		5	0			
	New type of elements to replace unsuitable ones	5	4	6			
		£5	9	6	£5	9	6
3. Fish fryer ...	Nil		–			–	
4. Boiling plate ...	New elements and fire clay formers ...		17	6		17	6
5. Electric range ...	New switches and fuses	1	16	0	1	16	0
6. Hobart machine ...	Various	1	10	0	1	10	0
7. Potato peeler ...	Nil		–			–	
					£10	17	0

Regarding the renewals and repairs to the grill, costing £5 9s. 6d., I would point out that this had to be done very early in its use, and that the new type which was put in as a replacement has been found very satisfactory and given no further trouble. It will therefore be seen that the renewals and repairs, excluding this unfortunate occurrence, are very small.

At this Institution, meals were cooked for one year for an average of 198.1 persons daily, that is 136.5 patients and 61.6 staff, with an expenditure of 36,400 units of electricity, costing for fuel, oil, &c., .819d. per unit, or £124 4s. 3.6d. per annum, exclusive of renewals and repairs, £10 17s. 0d. as shown above. The cost of electricity to the Institution has been reduced this year to .51d. per unit.

When considering the adoption of electricity for cooking purposes in an Institution, from our experience we would recommend that the following points should be borne in mind :—

A.—Relative cost in comparison with other methods, *i.e.*, gas or house coal.
B.—Construction of apparatus, as this has a distinct bearing on the results obtained and on the cost of renewals and repairs.
C.—Relative ease of control and economic operation of appliances.

A. In regard to " A," where a generating plant is already included in the equipment of an Institution and is of sufficient capacity to meet the increased demand made by electric cooking apparatus, the true cost of the supply for cooking is that of the extra fuel, water and lubricating oil necessary to generate the extra units only. No extra power house staff is required in such a case by virtue of installing electric cooking apparatus. Where the cost of electricity per unit is below 1d. an economy can be shown in comparison with gas at 3s. 4d. per 1,000 cubic feet, and with house coal at 42s. a ton delivered into the bunkers. With house coal it must be borne in mind that the kitchen staff has to be augmented by the employment of a kitchen porter at £2 to £2 10s. per week, also the necessity of redecorating the kitchen and of the extra cleaning materials. The condition of the walls, ceiling and floors of the kitchen of this Institution is very little altered since its coming into use. No redecoration has had to be done. I have very little doubt that when the proposed large power stations are built throughout the country and the cost of electricity to the consumer is below 1d. per unit, economy by this type of cooking will be made by Hospitals.

B. In regard to " B," all the main cables to the various apparatus should be controlled by robust iron-clad double pole switches and fuses. All apparatus should have switches giving three heats, *i.e.*, full, medium and low, and be fitted with indicating lamp to show when they are on. All metal work should be bonded and efficiently earthed to prevent any possibility of shock to the staff. In the ovens the elements should be loaded to a black heat only, *i.e.*, about 500° C., and should be suspended in such a manner that they are free to move in all directions when expanding when heating, and contracting when cooling off. The connections to the elements should be made by a flexible pigtail to a binding screw separate from the suspension bolts. The elements should be guarded by a sheet iron screen, not perforated, to obviate danger of shock due to accidental contact and prevent fat, &c., splashing into the elements. The ovens should be efficiently lagged to prevent radiation, an important point. The fryers should have their elements rigidly clamped to the outside of the bottom of the container. It is essential that there is as intimate contact between the element and the base as is possible, and the element must be kept rigid.

In the grills an element of spirally wound michrome wire supported in fireclay holders throughout its entire length, above the cooking space, and loaded to a red heat, *i.e.*, about 700° C. to 750 C., gives the best results. As this element can only be guarded by a wire mesh guard when chops, sausages, &c., are being cooked, care must be taken to keep the containers as low as is possible, otherwise the fat, &c., will be thrown on to the elements causing hot spots and rapid breakage of the wire of the element.

For hot water boilers for tea the best results are obtained, using electrical heating, by having one element in a storage tank which can be thermostatically or manually controlled, loaded to maintain the water at about 140° F., with a second element controlled by the tap or separate switch which raises the water to boiling point as it is drawn off as required. For cooking small quantities of food other than meat, *i.e.*, vegetables, eggs, sauces, &c., for one or two persons, apparatus in which the element is rigidly clamped to the bottom of the container should be used, and separate plugs and switches of the single pole type provided for this purpose. The same applies to boiling two or three pints of water, which should be done in an electric kettle. The open type hot plate sometimes used for these purposes cannot be recommended, on account of liability to breakage, due to food and water boiling over, and to the length of time taken, this apparatus not being so efficient.

C. As regards " C," where the kitchen staff has been properly trained and educated in the uses of electrical cooking apparatus, considerable economy in fuel expenditure can be obtained. The three heat controls mentioned above enable the operator to raise the necessary temperature quickly, and this can then be maintained by the use of a smaller current. Also

in cooking meat in the ovens the large loss in weight experienced in gas cooking due to evaporation of moisture from the joints, which cannot be prevented as a through draught must always be present in the oven when burning gas, can be greatly reduced by intelligent use of the pores and the heat then reduced, excellent results are obtained. Also, with electrical cooking, when the best conditions have been learnt from experience, for any particular process, these conditions can always be duplicated with absolute certainty, a quality that it is quite impossible to obtain with either gas or house coal as fuel. Electricity can, in addition to the above, be used in the kitchen to materially reduce time and labour required in various operations, such as potato peeling, mincing, sausage making, soup straining, potato mashing, coffee grinding, &c., by the installation of potato peelers and the Hobart, or similar apparatus driven by electric motors.

I would express my gratitude to Miss E. Salter, the Matron, and Mr. F. G. Miller, Staff Engineer, for their able assistance in the compilation of this article.

THE PROVINCIAL HOSPITALS A HUNDRED YEARS AGO.

BY

R. H. P. ORDE, B.A.

THE REPORTS.

The Annual Report of 'the State,' so the title ran, of the General Infirmary at or near one of the provincial towns of England a hundred years ago, was usually printed on two large double sheets very much after the style of the early newspapers.

A woodcut of the building adorned the front page. The names of the office bearers, the report of the board of management, the statistical and financial figures, the list of subscribers and the more important of the rules of the institution occupied the remainder of the space.

THE BUILDINGS AND SITE.

Variety was not a distinguishing feature of Hospital architecture in those days. The woodcuts show a plain "I" or "E" shaped building of four stories—basement, ground floor, chamber and attic—with a central porched entrance, reached, when the basement was only slightly sunk below the ground, by a double flight of steps. A pediment, providing space for a clock and a lantern surmounted by a weathercock relieved the austerity of the facade. In many towns the old buildings can still be seen half buried in the new.

The woodcuts also show that the Hospitals stood on well-chosen sites. They depict gardens and open spaces. Had imagination and foresight safeguarded so valuable an inheritance from the encroachment of factory and tenement, there would never have been any justification for the myth that the slum was the habitat of the Hospital. The last hundred years has supplied too many instances in the Hospital world of missed opportunities; nor are they altogether wanting even to-day.

The building of a hospital was a rare event during the decade 1820-30, and there is little material on which to found any estimate of the cost. If the first annual report of a south country Hospital, dated 1825, can be trusted, construction (excluding the purchase of site) was carried out at about £150 a bed. In the same year, a Hospital was built in London, and here the cost appears to have been a good deal less—under £100. No doubt costs varied then, as widely as to-day, and the £100 to £200 of 1825 corresponds to the £500 to £1,000 per bed of 1920-25.

The cost of equipment appears to have been about one-tenth that of building—a proportion which still holds good.

THE NUMBER AND SIZE.

The provincial Hospitals were distributed approximately thus:—

England	80
Wales	4
Scotland	14
Channel Islands	2

Of these, possibly three or four had more than 200, and ten more than 100 beds. The

rest were of all sizes from 100 beds downwards. Twenty out of the hundred were Special Hospitals—eleven being for diseases of the eye.

THE WORK.

Some idea may be formed of the character and volume of work of this period, if we assume a Hospital of 100 beds, and attribute to it characteristic activities, all of which would not, of course, be found in any one single institution.

Admission.—To such a Hospital sick and lame applicants, unable to pay for treatment, brought subscribers' letters of recommendation at a certain hour on one day in the week. They were interviewed by members of the Board, assisted by one or more of the honorary staff, and admitted as in-patients or as out-patients, or rejected as unsuitable. Urgent cases were admitted at all times by the Resident Apothecary or by the Matron. Such admissions were reported at once to the honorary staff and subsequently to the Weekly Admission Board.

An interesting copy of the " Rules of Professional Conduct to be observed by the Physicians and Surgeons," printed about this time, gives certain axioms governing " certification of the admissibility of diseases."

> " Diseases must be capable of speedy cure, because the object is to cure as many as possible and because the inbred disease of Hospitals will almost invariably creep, in some degree, upon one who continues a long time in them, but will rarely attack one whose stay is short."
>
> " No infectious diseases must corrupt the air, or by specific contagion spread their baneful influence amongst other patients."
>
> " Diseases that require in a peculiar degree a fresh pure air, are improper to be received into an infirmary."
>
> " They must afford hope of radical cure and must require the superintendence of skilful persons."

Children under seven years of age, except those on whom surgical operations were to be performed, were not admitted. Fever cases, where there were fever wards (and a mighty controversy raged at this time on the subject of fever wards in Hospitals) could be sent in by anyone on payment of 10s. 6d. a week to the Hospital and £1 1s. to the physician. The master had to pay 5s. a week for his sick servant or apprentice; the soldier his subsistence money, if admitted; the Guardians of the Poor for the board of any they sent in.

Under the same management and with the same physicians and surgeons, an asylum for the insane was sometimes linked with the Hospital. In the asylum, payments for board and for attendance were fixed by the Committee in accordance with the means of the patient. The asylum had a separate Lay Governor and a Matron, but it was the duty of the Infirmary Apothecary to visit it each day.

Practice varied with regard to venereal patients. In some Hospitals there were lock wards.

Though many of the Hospitals were " County " Hospitals, no patients were rejected, if otherwise suitable, on account of their being settled out of the county.

The Waiting List.—Those eligible for admission, but for whom there were no vacant beds, were registered in a book and sent for as opportunity arose.

Length of Stay.—The average length of stay at this time was between 40 and 50 days, and a Hospital of 100 to 120 beds would treat from 700 to 900 patients in the year. There was, however, considerable variation. At Glasgow, for instance, at a slightly later date—1835—the length of stay is given as :—

Fever cases	21 days.
Medical cases	36 ,,
Surgical cases	32½ ,,
All cases	28½ ,,

At Nottingham at about the same date, patients stayed in 50 days, and at the Devon and Exeter Hospital in 1820 in-patients averaged a stay of eight weeks.

Hospital Pressure.—The frequency of allusion to lack of accommodation points to a fuller occupation of beds than might be supposed from the somewhat leisurely arrangements made for admission.

In the first report of the West Sussex, East Hampshire and Chichester Infirmary (1826), it is recorded that the wards were filled with patients almost as soon as they were opened.

> " No narrow prejudice, as had at one time been anticipated, has held the sufferer from coming to seek relief."

At another Hospital where there were more patients than beds, the Committee give some relief to their feelings by informing their supporters that :—

> " this circumstance tends to show the precipitancy of those animadversions which in the infancy of its establishment were made on the magnitude of the Hospital."

Classification of Patients.—Unusually detailed statistics are given in the reports of the " General Hospital, near Nottingham," about this date. The Tables show that the town sent in three patients for every two from the county, and that men were to women in a similar proportion. More than three-quarters of the patients belonged to the wage-earning classes, and, if the figures can be accepted, one-quarter had a history of illness exceeding two years prior to admission!. Out of the 566 patients treated :—

17	are	tabulated	as	suffering	from Bronchitis.
27	,,	,,	,,	,,	Dyspepsia.
28	,,	,,	,,	,,	Fractures.
16	,,	,,	,,	,,	Heart.
17	,,	,,	,,	,,	Ophthalmia.
14	,,	,,	,,	,,	Phthisis.
42	,,	,,	,,	,,	Rheumatism.
50	,,	,,	,,	,,	Scrofula.
19	,,	,,	,,	,,	Syphilis.
26	,,	,,	,,	,,	Tussis.
24	,,	,,	,,	,,	Ulcer of leg.

Operations.—Operations were not numerous. Between the years 1782 and 1837 at Northampton there were :—

351	Amputations.
14	Trepannings.
100	Cuttings for the stone.
3	Lithotripsies.

an average of less than ten great (that is major) operations each year. At Glasgow Infirmary in 1836 out of a total of 3,260 in-patients, the operations list, great and small, did not exceed 150. In 1925 a small provincial Hospital, treating no more than 560 patients in the year, performed more than double this number—396.

Mortality.—The rate of mortality was low; so low, indeed, as to suggest that the sick declined to go into hospital if they anticipated death, or obtained their discharge in order to die at home. The deaths recorded in the reports frequently do not amount to 4 per cent. of the in-patients treated. At Glasgow, however, where there may have been less prejudice on the matter, and where the figures are definitely given, the rate was higher.

Fever patients	10 %
Ordinary medical	14 %
Surgical	9 %
All cases	11 %

Burns, erysipelas, heart disease and phthisis, account for one-third of all deaths in the Glasgow Infirmary in 1835, except those in the fever house.

The Out-Patient.—It was about the beginning of the last century that the out-patients began to be numerous. By 1825, a Hospital treating 700 to 900 in-patients would have an out-patient department numbering 3,000 to 4,000. There were, however, notable exceptions, *e.g.*, at Liverpool in 1827 the in-patients numbered 1,776, out-patients only 1,060; at the Devon and Exeter Hospital in the same year the in-patients also out-numbered the out-patients.

Out-patients attended on one morning of the week, bringing fillets for bleeding and phials and gallipots for medicine. Trusses were supplied, but efforts were made to secure payment where possible.

THE SOURCES OF SUPPORT.

The following Table gives a comparison of the sources of support in 1825 with those of 1924 :—

	1825.	*1924.*
Proportion of Income derived from Gifts	88 %	43 %
,, ,, ,, ,, Interest on Investments ...	11 %	23 %
,, ,, ,, ,, Earnings	1 %	34 %

Widely as these proportions differ it is of interest to note that there is not one single source of income available to-day the counterpart of which cannot be found in embryo in the records of a hundred years ago.

There was no Insurance Act, but there were payments by Benefit Clubs. There were no organised Contributory Schemes, as we know them, but there were Workmen's Contributions. In one report the names of 94 firms are given at which the workmen contributed a total of £464, and the Committee comment thus :—

> " This is, without doubt, a gratifying statement. It shows the estimation in which the Infirmary is held and is creditable to the independent spirit of the contributors. They and their families when sick would have found admission to the wards through the medium of their employers, but there is an honest pride in showing their goodwill that the benefit which they receive should not be altogether gratuitous."

The value of mass contribution was well understood. One report refers to :—

> " Congregational collections which enable those charitable persons who cannot afford to subscribe two guineas a year to contribute their mite—a mite which it would be insulting to believe there are many who would not be ready to put into the treasury if the opportunity be afforded."

There were no paying wards, but certain facilities for treatment—baths, electrical treatment, massage—were allowed to the wealthy on payment. There were no public authorities as we have them to-day, but payments were made by the Guardians of the Poor for the treatment of those for whose care they were responsible; and the frequent reference in the rules to the ineligibility of soldiers for admission (except on furlough, or for payment) shows that the hospitals even of that day did not see why they should relieve the State gratuitously of any of its obligations.

Indeed there was one source of income which has disappeared almost altogether, unless we can regard the present-day government grant as taking its place. Year by year the

hospitals received a by no means inconsiderable sum from fines, either voluntarily inflicted, or agreed to by the injured party, or granted by the magistrate. The following are typical :—

" A sin-offering from the person who committed a trespass and outrage	£2 2s. 0d.
" An outrage at Mr. George Webb Hall's, Sneed Park	£5 5s. 0d.
" Martin Cheek shot a dog	£2 2s. 0d.
" A gentleman too scrupulous to take it	£7 0s. 0d.
" Assault on Charles Bull, Police Officer, whilst in execution of his duty	£5 0s. 0d.
" A moiety of penalties levied under the Game Laws "	15s. 0d.

The modern students' fees are represented by the fees paid by apprentices, which varied apparently with the Hospital.

Social efforts were by no means neglected, and Bazaars, Ladies' Repositories, Concerts, Dinners, &c., all contributed their quota to the income side of the account.

EXPENDITURE.

In spite of occasional frank and somewhat disconcerting confessions of inaccuracy in the old reports, their figures afford some material for comparison. In 1825, food for example, accounted for nearly half the cost of a patient—in 1925 it is less than a quarter. The figures of the main items are :—

	1825.	*1925.*
Provisions	46 % ...	22 %
Surgery and Dispensary	20 % ...	9 %
Domestic	15 % ...	22 %
Salaries and Wages	12 % ...	36 %
Misc. Estab. Admin., &c.	7 % ...	11 %
	100 %	100 %

The difference between the figures of " Surgery and Dispensary " and of " Salaries and Wages " in the two years is very striking.

Provisions and Dietary.—The Committee of a Hospital in 1815 informed their supporters that they had reduced expenditure by making, with the concurrence of the honorary staff, changes in the diet of the patients. How did they manage it?. To take shelter behind the honorary staff is not altogether fair. Before the change, the dietary (that of a modern Hospital is added for comparison) was :—

	1815.	*1924.*
Breakfast ...	Milk pottage, 1 pint.	Tea, 1 pint. Bread and Butter. Porridge, Fish, Eggs, Sausage or Bacon.
Dinner ...	Meat 8 ozs. Vegetables 4 ozs. on four days of the week. Rice Pudding or Baked Pudding on three days of the week.	Meat 4 ozs. Potatoes. Green vegetables. Milk Pudding.
Tea ...	—	Tea. Bread and Butter and Jam twice a week
Supper ...	Milk or Broth 1 pint. Bread and Beer without waste.	Milk and Bread ½ pint, or Soup and Bread, or Milk Pudding. Bread without waste.

It is possible, however, that Hospital feeding was not so Spartan as this dietary might lead us to suppose. Many of the Hospitals had ground attached, and references are not infrequent to gardeners, vegetables, cows and pigs. It is evident that a considerable amount of farm produce was not brought into account. But, indeed, there are other indications that the patients received in reality a plentiful supply of food. The figures happen to be given in two reports and we set them side by side for comparison.

Consumption per 100 Occupied Beds.

	1825.	*1924.*
Meat (including fish and poultry) ...	20,000 lbs. ...	25,000 lbs.
Flour	32,816 lbs. ...	35,000 lbs.
Milk	5,000 gallons ...	8,200 gallons.
Sugar	4,630 lbs. ...	5,200 lbs.
Tea, coffee, cocoa	306 lbs. ...	2,730 lbs.

The figures for 1825 do not show up so badly when we remember that as the bed carries both patient and staff there were in 1924 probably 40 more mouths per 100 beds to consume the meat,, flour, &c., than in 1825.

The great difference between the dietaries in 1825 and the present time lies in the proportion which meat, bread and malt liquors bear to the whole. These three items accounted in 1825 for 75 % of the total cost of feeding. To-day, they do not account for more than 30 %. The majority of Hospitals had then their own brew-houses and spent on beer nearly twice as much as they did on milk. To-day, the cost of the milk consumed is fifty times greater than that of the malt liquors.

Fish was not a common article of Hospital diet even in the seaport towns, nor did the Hospitals spend much money upon groceries, tea or coffee. The price of tea at that date was almost prohibitive. Gifts in kind are not often mentioned, but no doubt country friends brought in eggs and butter then as now.

Complaints regarding the cost of commodities were frequent; the following are some of the prices quoted in the Reports:—

Milk	8d. to 1s. per gallon.
Meat	5d. to 8d. per lb.
Bread	4¾d. to 11d. a quartern loaf.
Butter	9d. to 1s. 5d. per lb.
Cheese	56s. to 70s. per cwt.
Coals varied very greatly with the locality, but in a coal area ...	10s. per ton.
Eggs	10d. to 2s. per score.
Sugar	10d. to 1s. per lb.
Soap	52s. to 80s. per cwt.
Tea	5s. to 8s. per lb.
Coffee	1s. 8d. per lb.

Drugs and Dressings.—The Dispensary, or " Shop " as it was called, was administered by the Resident Apothecary and his apprentices. The lack of accuracy in the composition of medicines by these apprentices is specifically referred to as the reason for the introduction of regular dispensers. In those days drugs were, no doubt, held in higher esteem. In any case, the requirements of the physicians bulk far more largely in the accounts than those of the surgeon, and amount to more than three-quarters of the total. If one may judge from a questionnaire that was circulated at this time by a Hospital Secretary who was uneasy about his expenditure:—

Opium,
Sarsaparilla,
Lint,
Oil of mint,
Spirits of wine,
Rape oil,

were selected as largely used and therefore most suitable for purposes of enquiry. Sometimes prices are given of certain articles :—

Quinine was 8s. to 10s. an oz.
Whale oil, 2s. 5½d. a gallon.
Leeches, 1d. to 2d. each.

Few reports omit to appeal to the public for old linen for dressing purposes.

Salaries and Wages.—Salaries and wages appear to have been very uniform throughout the country. The following were customary payments :—

Chaplain	£30.
Apothecary	£60 to £70.
Matron	£40.
Secretary	£30 to £40.
Nurses	£14.
Assistant nurses	£10.
Night nurses	1s. per night.
Porter	£10 to £15.
Cook	£11.
Kitchen maids	£7.

An Apothecary, when he combined the three offices of House Surgeon, Apothecary and Secretary, is recorded as having received £150 per year.

STAFF.

From the reports of the same small provincial Hospital in 1836 and in 1924, we can gather some idea of the change that has taken place in the matter of staff :—

	1836.	*1924.*
Average No. of beds occupied	69	76
No. of in-patients treated	605	1,270
No. of out-patients treated	1,107	5,000
Administrative staff ... ... }	1	2
Medical staff ... ... }		3
Nursing staff	8	36
Domestic staff	5	23
Works and garden staff	1	4
	15	68

At this Hospital the honorary staff numbered 5 in 1836—in 1924, 19.

The Honorary Staff.—The post of Honorary Physician could only be held by a University graduate; that of Honorary Surgeon by a member of one of the Colleges of Surgeons. The House Surgeon and Apothecary was required to give evidence of having regularly studied medicine, anatomy and surgery, and of being acquainted with the general mode of Hospital practice.

The code of rules of professional conduct, already alluded to, helps us to picture the honorary staff of those days.

"They are conjured to unite in their deportment, tenderness with steadiness and condescension with authority.

"They must not oppose even the prejudices of the sick with harshness.

"No discussion concerning the nature of the case must be entered into before the patient.

"The choice of the physician cannot be allowed the patient, but personal confidence being of no less importance towards the relief of the sick poor than of the rich, it is urged that the partiality of patients should be indulged by calling into consultation the favourite practitioner.

"Temperance is incumbent on the faculty, as life may depend upon a steady hand, an acute eye, an unclouded brain.

"Staff consultations are not to be confined to serious operations only.

"Accurate monthly and yearly records are to be kept of whatever is extraordinary and interesting in Hospital practice.

"Although they should pay attention to economy in general, they must not suffer themselves to be restrained, by parsimonious consideration, from prescribing drugs of a high price and wine when required."

There is no reason to believe that practice was at variance with precept. It is plain that a spirit of kindliness was deemed as important in a Hospital in 1825 as it is to-day.

The last precept of all reads grimly to modern ears:—

"During the performance of operations a decorous silence shall be observed. It may be humane and salutary, however, for one of the attending physicians or surgeons to speak occasionally to the patient and to give him assurance, if consistent with truth, that the operation goes on well and promises a speedy and successful termination."

The Apothecary and His Apprentices.—The Apothecary and House Surgeon was often the Secretary.

He was responsible for the following duties:—

(1) The charge of what was known as the "Shop."

(2) The purchase, care and issue of drugs and dressings.

(3) The preparation, or the superintendence of the preparation by the apprentices, of all medicines prescribed.

(4) The instruction of the apprentices—for this work he received a special fee.

(5) Visiting each department of the Hospital twice daily.

(6) The keeping of the patients' admission register.

(7) The making up of the diet cards and the diet books.

(8) Visiting (in some few Hospitals) patients in their own homes.

The apprentice was taken on probation for three months. He was then bound to the Apothecary for five years, the House providing him with board and lodging. He had to pay in three instalments £126—one half of which went to the Apothecary, the other for the purchase of books for the Medical Library.

The Nurses.—There was little distinction between domestic work and nursing a hundred years ago. "Nurses and other servants" are classed together in the rules. The nurses are, indeed,

enjoined to pay attention to the state and symptoms of the patients and to administer the medicines prescribed according to the directions given; but most of the other rules, both for the Matron and the Nurses, are of a purely domestic character. One can only hope that certain of the rules were interpreted in a liberal spirit. Sheets were to be changed once a fortnight, the rest of the bedclothes once a month if the patient had sores! Night caps and stockings were changed once a week. Those patients who did not use either the cold or warm bath had to have their feet washed every Tuesday evening!

The Nurse entered on her " business " at 6.0 a.m. in summer and 7.0 a.m. in winter. At 10.0 p.m. she had supper and at 11.0 p.m. she had to be in bed. It is to be supposed that she received breakfast and dinner, though no mention is made of them in the rules.

On one day in the year there was a general inspection of linen and bedding by ladies who were either subscribers or the daughters of subscribers. These ladies were desired to give such directions or information to the Committee as they might deem necessary. It would be interesting to obtain the considered opinion of the present day upon such a practice, not only from the modern Matron, but also from the subscriber's daughter.

The patients were expected to assist in the domestic and in some of the nursing work, if considered fit to do so by the doctor. " A patient," so the rule runs, " becoming much worse in the night, might " (permissive) " desire some other patient, who is able, to call the nurse so that application, if necessary, may be made to the House Surgeon."

The Voluntary Hospital to-day is larger, more elaborate and busier than it was a hundred years ago, yet it is not Change that a reading of the old records impresses most strongly on the mind. A hundred years has not altered the outlook, nor discovered any alteration in the spirit with which difficulties are met and overcome. Then, as now, Hospitals were in the forefront of the fight against disease; and it is this relationship to their surroundings, that must be kept in mind, in drawing any comparisons.

The following sentence which opens the Report of the Liverpool Infirmary for the year 1820 expresses somewhat clumsily, but none the less truthfully, the aim of the Voluntary System. It might with equal truth be written of the Hospitals to-day :—

> " The erection of infirmaries, by the contributions of individuals, and the support of them by private subscriptions, are, with few exceptions, peculiar to the British nation, of which the Christian and patriotic spirit is also displayed in the very general determination that relief to the sick poor shall not be distributed in a niggardly manner. Hence has arisen the observation of foreigners, that in England the poor are accommodated in palaces."

PAWNBROKING AND HOSPITALS.

BY

SIR D'ARCY POWER, K.B.E., F.R.C.S.Eng.

Pawnbroking and Hospitals at first sight do not seem to bear a very intimate relationship the one with the other except that habitual users of the pawnshops are more likely to need the services of a Hospital. But at divers times and in various countries the profits of pawnbroking have been utilised for the upkeep of Hospitals, though this has only been possible when pawnbroking has been a State or Municipal undertaking.

The lending of money to the poor with or without interest, but always in return for some pledge or guarantee, is of ancient date. The first institution of which there is any certain knowledge was in the time of the Emperor Augustus (B.C. 7—A.D. 14), who, early in his reign, established a fund derived from the confiscated property of criminals, for the purpose of lending to the poor. Interest was not taken, but a pledge double the value of the loan was demanded.

Tiberius (A.D. 14—36) also created a large fund from which advances were made for a term of three years to those who could give security in land equivalent to twice the value of the loan. In like manner Alexander Severus (A.D. 193—211) lent money at a low rate of interest or advanced it to the very poor, without charging any interest, to allow of the purchase of land, the capital sum being repaid by instalments in a manner not very dissimilar to that which is adopted by our own Colonial Governments.

In the first century of the Christian era free gifts were collected and preserved in the churches to defray the expenses of divine service and to relieve the poor. The collections thus made are said to have been called " Montes " or heaps, and it is thought that by the addition of the word " pietas " may have arisen the term " Sacri Monti di Pieta " or " Mont de Piété," which is now applied to the charitable pawnshop in many European countries.

The charitable pawn office gradually fell into disuse in religious circles, and the State ceased to lend. Money, therefore, had to be borrowed from the Jews and Lombards at high rates of interest throughout the earlier Middle Ages. It lingered, however, in the Universities, where " chests " were endowed by various benefactors. At Oxford, for example, Bishop Grossteste established a chest in the year 1246, which he placed in charge of a brother of the Priory of St. Frideswide, with whom he associated two discreet men, to lend money without interest to poor scholars. A cup, a garment, a precious manuscript or an illuminated missal was required as a pledge, which might be sold at the end of a year if it had not been redeemed. The right of borrowing was restricted to those whose income from benefices did not exceed ten marks—a mark being two-thirds of a pound or 13s. 4d. A Master of Arts might borrow up to a mark; a Bachelor to the amount of eight shillings; but an undergraduate could only receive five shillings as an advance. The University chest evidently met a want for it was soon copied, and to this day, although under very different conditions, the expression " borrowing of the University Chest " is still in familiar use at the University.

The Church for a long time maintained that it was an unchristian act to take interest for money lent, and it was not until a Bull promulgated by Leo X (1513—1521) declared the Holy Mountains of Piety to be legal that lending houses were established on a large scale.

The first lending house in Italy was founded by Barnabas Interamnensis of Terni, and was under the supervision of the Franciscans. Barnabas, originally a physician, became a Doctor of Theology and died in the first monastery established by the Franciscan Order at Assisi, in the year 1474. He observed how much the poor suffered from the usurious dealings of the Jews whilst he was preaching at Perugia, and he proposed to collect a fund out of which money might be lent on pledges taken as security, a small monthly interest being taken to pay expenses. Fortunatus de Copolis, a distinguished lawyer, who became a Franciscan after the death of his wife, heartily approved of the scheme and assisted in carrying it into execution. The matter was referred to the University of Assisi, which looked favourably upon its inception, and a sufficient sum of money was quickly obtained by preaching, to allow of the opening of a lending house.

The first Mont de Piété was opened in 1464, a second was established at Orvieto in 1467 with the sanction of Pope Paul II, and a third at Viterbo in 1472 under Pope Sixtus IV. Monts de Piété were in use in most of the large Italian towns before the end of the fifteenth century, but at the beginning of the sixteenth century they were again attacked by the Dominicans and were defended by the Franciscans. The discussion was only ended when Leo X declared during the tenth sitting of the Council of Lateran that " lending houses were legal and useful; that all doubts to the contrary were sinful, and that those who wrote against them would be excommunicated." The whole assembly, with the single exception of one archbishop, voted in their favour, and a decree of the Council of Trent subsequently confirmed their legality. Opposition finally subsided, and in 1565 Saint Charles Borromeo, the Pope's legate at the Council of Milan, ordered all governments and ecclesiastics to assist in their formation.

The first Mont de Piété in Germany was authorised by the Emperor Maximilian I in 1498. It was granted to the citizens of Nuremburg, that such of their fellow-citizens as were not able to carry on their trades, callings and occupations without borrowing and without pledging their goods, should receive money on demand according to their trade and circumstances for which pledges, caution and security should be taken; that a certain sum should be exacted at the time of payment by way of interest; that the clerks and managers should receive salaries, and that the surplus, if any, should be employed for the common use of the City of Nuremburg like any other public fund. The Magistrates of Augsburg granted the sum of 30,000 florins in 1591 to found a Mont de Piété, and issued regulations for its proper conduct in 1607. A lending house was established at Amsterdam in 1568 upon the recommendation of William, Prince of Orange, and the Archduke Albert, acting upon the advice of the Archbishop of Mechlin, established a Mont de Piété at Brussels in 1619, at Antwerp in 1620, and at Ghent two years afterwards.

In France the Sorbonne could not for a long time divest itself of the prejudice against the receipt of usury, and although Louis XIII founded a Mont de Piété at Paris in 1626 it had to be closed in the following year. A second attempt was made at Versailles in 1695, but it failed also. All difficulties were overcome at last, and a Mont de Piété was opened at Paris in 1777 by a Royal Ordinance of Louis XVI, and soon proved so successful that it is said to have frequently had in its possession forty casks full of gold watches which had been pledged. The Revolution swept away the charitable lending houses, but the poor soon clamoured for their reopening. In 1804 Buonapart by the code Napoléon put them on a secure basis by enacting that no lending house could be established, but to the profit of the poor and with the approbation of the Government. It was also declared that the object of these institutions was to lower the rate of interest and to devote the profits to hospitals.

Monts de Piété were soon established in every part of France, and the regulations for raising the capital required to support them are worthy of notice. It was enacted at Bordeaux by the Ordinances of 1804 and 1806 that " The capital of the Establishment is to be the equivalent of £24,000 raised by shares or loans. Eight per cent. interest was to be paid to the lenders, the property of the hospitals forming the security. The profits were to be divided into two equal shares, one to belong to the hospitals, the other to the shareholders." Within

a few years the profits had been so large that the original subscribers were paid out and more than one fine hospital had been built and endowed. The municipal pawnshops in France are still supported by gifts and loans, the profits going to the Assistance Publique, which corresponds in some measure to the Metropolitan Asylums Board in London. There are, too, a few endowed pawnshops which charge no interest.

In England the lending of money on pledges has always been in the hands of private individuals, and no attempt has been made to utilise the profits for any public purpose although the Salvation Army once projected a scheme and in 1894 the London County Council had the matter under consideration, but without result.

Matters were different in Ireland where Mr. Matthew Barrington brought forward a scheme for opening a charitable pawn office at Limerick, the profits from which were to support Barrington's Hospital in that city. A public meeting was held in the City Court House at Limerick, on October 28th, 1836, at which Mr. Barrington gave some interesting particulars. He stated that it was difficult to ascertain the actual profit of the several pawn offices in the city, but on a particular day he had made it his business to pawn one article in each of the local offices; all the tickets, he said, are numbered, and by deducting the number of the intervening tickets after a certain lapse of time he was able to gain the information he wanted with some degree of accuracy. On 15th October he pawned 25 articles in twenty-five different offices, and taking the number of the ticket in one of these offices he found it was 92,119; on the 22nd of October he pledged another article in the same office and the ticket given in exchange for it was 93,400, showing that 1,281 pledges had been taken in a single week, which was at the rate of 66,612 in a year. He then proceeded to analyse the figures at the other pawnshops, the highest number of articles received by a single shop in a week being 1,281 and the lowest 55. Adding his results together he showed that 735,956 articles had been received by the twenty-five pawnbrokers, with a profit of £3,066 1s. 4d. from the sale of the tickets alone. He proposed, therefore, that a charitable pawn office should be established in Limerick with a capital of £15,000, the debentures to bear interest at 6 per cent., and the profits, which he calculated should be £4,000 a year, were to be allocated to the support of all the charities in the city. The idea does not seem to have been limited to Limerick, because in 1838 there were eight charitable pawnshops in Ireland. They proved unsuccessful, and it is noted that in 1841 they had an adverse balance of £5,340. Three only were left in 1847, and eventually even these collapsed. It does not appear, therefore, that such institutions are suited to the genius of the English-speaking races, nor is it likely that the Voluntary Hospitals would gain much support by upholding a scheme for the establishment of a Mont de Piété.

HOW I REMEMBER ABOUT THE MONT DE PIÉTÉ.

Extracts from a Letter from Sir Charles Barrington, Bart.

"Dinner was over, and my father and his old friend, Dr. Owens, had settled down comfortably to their filberts and port. The ladies had retired. Their day's shooting had been a pleasant and happy one. They were in capital form and began talking, as men will do on an occasion like this, of the wonderful shots they had made, the behaviour of the birds, the cleverness of their setters, &c., &c.

When this topic was exhausted they turned to speak of other things and amongst them Barrington's Hospital and the Mont de Piété. This must have been in the year 1858, the year of the great comet. Being only a boy then I was much impressed by my elders' conversation, and I have a clear recollection of what was said.

In those days dinner was at 6 o'clock and there was no such thing as five o'clock tea! The children were allowed ' to come down for dessert ' and I was one of them, and that was how it came about that I was present.

My father spoke of the Mont de Piété, its fine situation and what a pretty little building it was, and the pity of its being a failure, having started so well on its career of usefulness. He explained to Dr. Owens that at the beginning it had been a great success so far as its work went. He also explained the advantage it was to the poor, and the point he chiefly insisted on was that there was no charge for the tickets. That was the kernel of the matter.

In an ordinary Pawn Office the person pawning goods was charged interest on the loan and *also charged for the ticket.* The Mont de Piété made no charge for the ticket. Thus the poor were charged at a much lower rate of interest on their loan than in an ordinary Pawn Office.

At that period there were not many who took an interest in Hospitals. Philanthropy as we know it was only in its infancy, and under these conditions the Barringtons presented a Hospital to the City of Limerick.

The City, however, had no one available to take an interest in the place, and thus the finances and management of the Mont de Piété, which being a business matter and required constant attention, were unfortuately allowed to slide indefinitely.

One fine day the Governors of the Hospital awoke to the fact that their Manager of the Mont de Piété had disappeared.

The books were then looked into, and it was found that he had embezzled a sum of about £3,000 which should have gone to the support of the Hospital.

My father even mentioned this gentleman's name (which I need not give here). Also that he turned up after some time in London and started there a well-known and successful business on the proceeds of his robbery.

After its débacle, so far as I know, the Mont de Piété never functioned again.

The story of the Mont de Piété must have made a considerable ' stir ' at the time. When playing as children in Fitzwilliam Square, if we did anything to displease the opposition, they always called us ' little pawn-brokers ' as a term of reproach!

For some years the Mont de Piété building was used as a police barracks, the large circular chamber being divided with brick walls to make it suitable for occupation. When the police left, the building was untenanted for many years and was finally taken down and the materials sold by auction, an act of real vandalism. The copper dome brought in a very substantial sum, and the fine stone pillars were said to have gone to New York to assist in beautifying a millionaire's residence.

The building itself was very picturesque, on the lines of the temple of Vesta. It was one of the landmarks of the city and was always known as the ' Montipite.'

The Mont de Piété also issued ' tokens.' Enclosed is a photograph of one. a copper coin about the size of a farthing, but its use I have been unable to discover.''

Sir Joseph Barrington, a name inseparably interwoven with the history of those times in Limerick, undertook in 1829, with his sons, to found a charitable institution for the relief of the poor of their native city. This was named Barrington's Hospital, and was opened for the reception of patients in 1831.

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